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Monthly Bulletin

WITH

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Volume 10

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FEDERAL SECURITY AGENCY • Social Security Administration

Children's Bureau

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Hershey Conference on Convalescent Care

Planning To Meet Polio Epidemics

Training Young Farm Workers for Safety

U. S. SEP 14 1945

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Assistant Editor Sarah L. Doran

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The photograph on the cover is used by courtesy of the New York Hospital, New York, N. Y.

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

Building the Future

The San Francisco Conference was in effect a meeting of the leading "umpires" of the world. They met to lay down the rules and establish the framework within which a new and improved game of international relations may be played. Much has been said and written during the last few weeks concerning the rules. Much more needs to be said and written concerning the players; that is, the men, women, and children upon whose integrity, ideals, and competence the final victory of lasting peace must depend.

The report of the National Commission on Children in Wartime, "Building the Future for Children and Youth," which has just been released, is devoted to those fundamental principles upon which the development and training of the players of this critical game must be built. The report stresses the need for the expansion of services, both public and private, for maternal and child health and for crippled children. "The health of children no less than their education is a public responsibility." For the fiscal year 1946, the maximum authorized for appropriation from Federal funds for grants to States for maternal and child health should be raised, the report points out, by approximately $50,000,000.

Need for a decided increase in child-welfare services is also emphasized in the report. In the majority of counties there is no child-welfare worker to assist in furnishing care to children in their own homes, to those coming to the attention of police, for adolescents stranded in war communities, or for those who need temporary shelter and detention. Others needing special care include the mentally deficient, the emotionally disturbed, and children who are born out of wedlock. Federal funds and local private funds must be made available in far larger amounts to provide these and similar services.

Extension and improvement of other social-security programs are also essential ingredients in an adequate training program for the future players in the game of national and international cooperation. No less important, and a matter that has been widely neglected during the war is child-labor legislation. The report recommends the adoption of a 16-year minimum for all employment during school hours and for work at any time in manufacturing and mechanical establishments.

Need for immediate study of such problems as a correlated mental-hygiene program for children and youth, adequate guardianship of children, and leisure-time services, is urged by the report. Programs for youth, including student aid, placement services, opportunities for combining employment and education, and problems of migrant youth are also recommended for early and careful attention.

On the much-discussed subject of compulsory military training, the commission report points out that no matter what formal program may be decided upon, the basic security of the Nation lies in vigorous efforts by both public and private agencies and the individual citizen to strengthen child life and the full and adequate development of youth.

This report should have the careful attention of parents, educators, physicians, the clergy, social workers, legislators, representatives of labor and management, and indeed all who have interest in and real responsibility for the development of our children and youth. It charts a course for the future in simple and practical terms.

Leonard W. Mayo
Chairman, National Commission on Children in Wartime
President, Child Welfare League of America

Publication of The Child, Monthly Bulletin, with Social Statistics supplements from time to time, was authorized by the Bureau of the Budget May 12, 1936, under Rule 42 of the Joint Committee on Printing, to meet the needs of agencies working with or for children for a regular channel of information on current developments, activities, policies, and programs for maintaining the health of mothers and children, providing child-welfare serv- ices, and safeguarding the employment of youth. Address The Child, Children's Bureau, U. S. Department of Labor, Washington 25, D. C. The Chil dren's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. The Child i for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at $1 a year; foreign postage, 25 cents additional single copies, 10 cents.

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CARING FOR CONVALESCENT CHILDREN

Conference at Hershey, Pa., points up the need to interrelate services

By KATHLEEN ALLEN

Director of Study on Convalescence,
National Society for Crippled Children

No easy formula can be offered for management of convalescence in children, said Dr. Joseph A. Johnston, Chief of the Pediatric Service of Henry Ford Hospital, at a conference on convalescent care for children, held at Hershey, Pa., April 19-20, 1945, by a committee of the National Society for Crippled Children and Adults. Ideal management of convalescence, Dr. Johnston went on to say, involves attention to every factor that affects growth and development, such as diet, infection, hormone activity, physical activity, and mental status.

The purposes of the conference, as stated by the chairman, Dr. A. L. Van Horn, Director of the Division of Health Services, Children's Bureau, were: "To review the basic physical, mental, and social needs of children during convalescence, to study the interrelationship of the various services for the convalescent child and the coordination of these services, to obtain a body of information regarding problems of convalescent care, and to stimulate thinking in this field among the various groups represented at the conference."

Discussing the emotional aspects of convalescence, Dr. Milton J. E. Senn, Psychiatrist, New York Hospital, and Associate Professor of Pediatrics and Psychiatry, Cornell University Medical College, urged that the child who had been ill and was returning to good health be considered as a living, changing person whose mind and body jointly share in his recovery and in the process of his growth. (It is expected that Dr. Senn's paper, and possibly others, will appear in full in an early issue of THE CHILD.)

Photograph by Philip Bonn, Children's Bureau

HAPPY AND BUSY, this young rheumatic-fever patient is on road to recovery, learning to make a scarf on a little loom supplied by the hospital where he is being cared for.

Convalescent care must meet the needs of the whole child, said Dr. Waldo E. Nelson, Professor of Pediatrics at Temple University, Philadelphia, opening a discussion among representatives of eight professional fields that contribute to the proper convalescent care of children—medical, nursing, physical therapy, occupational therapy, medical-social service, education, nutrition, and administration. Dr. Nelson gave as an example the child who had rheumatic heart disease. Such a child, he said, may recover from his physical illness without evidence of damage, but unless the persons taking care of him have kept him from having mental and emotional disturbances, the management of his illness is not satisfactory. Dr. Nelson told the conference that the necessity for concerted, organized, and properly balanced action by those who are essential to the care of the whole child overshadows all individual phases of convalescent care. No one person should be, or can be, most important, said Dr. Nelson, adding that this applies to the doctor as it does to the other essential personnel.

Nursing

Representing the nursing field, Isabelle Jordan, R.N., Director of the Sharon Sanatorium, Sharon, Mass., spoke of convalescent nursing of children as intelligent mothering plus trained service. A nurse, she said, to be successful, should instinctively cherish each child. The younger the child, the more physical demonstration of affection he will need, said Miss Jordan, and time must be found to allow for this. Even the older children need a well-timed pat, she added, an occasional tucking in at night, a sympathetic ear when something is bothering them, and sometimes a special personal chat.

Physical Therapy

Representing the field of physical therapy, Jessie L. Stevenson, R.N., President of the American Physiotherapy Association, said that the convalescent home that uses its physical therapist only for the corrective phase of her work is not getting the maximum benefit of the service she is prepared to give. Preventive services also are needed, said Miss Stevenson, and both the preventive and the corrective services that are begun in the hospital should be continued in the convalescent institution. Furthermore, the physical therapist should be used as a consultant in body mechanics and posture in all departments of the institution—the wards, the schoolroom, and the playground. And, Miss Stevenson went on, she can suggest adjustments in school furniture and play equipment that will permit correct use of the child's body in all his activities. The nurse, the teacher, and the person responsible for recreational therapy, she continued, should know the type and amount of general and local activity that are safe for the child, what positions are desirable, and what positions are to be avoided or to be permitted only for short periods.

Occupational Therapy

Occupational therapy is equally important for the 2-year-old and the 10-year-old, according to Claire Spackman, Director of the Curative Workshop of the Philadelphia School of Occupational Therapy and the Occupational Therapy Department of the Graduate Hospital of the University of Pennsylvania. Miss Spackman reminded the conference that long months of illness, in a hospital, in a convalescent home, or even in the child's own home deprive the child of the experiences, mental and physical, that he needs. No therapeutic program can take the place of normal life, she added, but it can compensate to some degree for opportunities lost. It is only with the fullest cooperation of the medical, nursing, social-service, educational, library, and physical and occupational-therapy departments that this can be accomplished, said Miss Spackman.

Medical-Social Work

The medical-social worker must be able to evaluate a child's social situation in terms of his physical and emotional needs, said Muriel Gayford, Lecturer in Medical-Social Work at Bryn Mawr College. She must also be able to present her findings to the physician, went on Miss Gayford, so that an individualized and appropriate decision may be made regarding convalescent plans for the child. In each step of the planning and carrying out of the treatment, she said, the medical-social worker must prove her ability to work with the child and his parents. The medical-social worker's contacts with the child will probably be not so numerous, nor the relationship so close, as it is for many of the other personnel in the hospital, Miss Gayford continued, but she is likely to know the child's parents more intimately than do the other workers concerned with the child.

Rheumatic Heart Disease

Discussing the child with rheumatic heart disease caused by rheumatic fever, Dr. Alexander T. Martin, Chairman of the American Academy of Pediatrics Committee on Rheumatic Fever, told the group that such a child should have as prolonged care as a child with tuberculosis. Because of their chronicity rheumatic fever and tuberculosis have this in common, he said, that bed rest is still the most effective therapeutic agent during the active phase of the infection.

Postwar Programs

During the postwar period more emphasis than ever will be placed upon convalescent programs for crippled children, said Lt. Colonel A. R. Shands, Jr., M. D., Chief of Surgical Office, Professional Division, Army Air Forces. The tendency, said Dr. Shands, will be to remove the patient from the active-hospital bed as soon as possible. More careful discrimination will be made between the hospital patient and the convalescent, he said; the convalescent program will include more types of children; and prevocational training will be given the younger child, as well as vocational evaluation of the child at a very early age. All this will lead to the more complete and earlier socialization of the child, continued Dr. Shands, and in the end this will result in a wider and more hopeful horizon for the child with a physical handicap.

Placement Services

Ethel Verry, Director of the Chicago Orphan Asylum and member of the faculty of the School of Social Work, University of Chicago, in sidering the placement of convalescent children, said:

> No one, at least no one who is informed or who has given any thought to the matter, would dispute the fact that the best place for a sick child to get well, as soon as he can get along without the highly skilled medical and nursing service and formal treatment available only in the hospital or institution, is in his own home. Since that fact is so obvious, the basic resources for convalescent care in any community should be in the form of service and aid to the child's family so that whenever it is at all possible the child can get the care that he needs, when he needs it, in his own home. But in a world where families live under housing conditions as deplorable as now exist in many communities, where others work outside the home and place their youngsters for long hours in nursery groups or day-care homes, where strained and unhappy and unhealthy family relationships and parental attitudes defy the skill of case worker and psychiatrist, there are sure to be children who, although they do get along somehow in their homes when they are well, simply cannot get well under the same conditions. The recognition of such situations, the diagnosis, if you will, of the need for foster-home placement as a convalescent measure, calls for a very wise and skillful weighing of the medical and social and emotional factors in each situation if serious mistakes in planning, with subsequent harm to the child, not to mention waste of community resources, are to be avoided.

* * * *

Among the other speakers who participated in the conference were: Kathleen Allen, Director of Study on Convalescent Care for Children; E. H. L. Corwin, Executive Secretary, Committee on Public Health

Relations, New York Academy of Medicine, New York; Helen Denecke, Director, Detroit Orthopedic Clinic and Sigma Gamma Hospital School, Detroit; Doris Langdon, R. N., Orthopedic Nursing Consultant, Connecticut Department of Health; Robert Lyon, M. D., Medical Director, Cincinnati Children's Convalescent Home, and Associate Professor of Pediatrics, College of Medicine, University of Cincinnati; Elise Martens, Senior Specialist in the Education of Exceptional Children, U. S. Office of Education; Claude W. Munger, M. D., Director of St. Luke's Hospital and Convalescent Home, New York; Winthrop Phelps, M. D., Director, Children's Rehabilitation Institute, Baltimore; Allen F. Voshell, M. D., Director, Orthopedic Service, James Lawrence Kernan Hospital and Industrial School of Maryland, and Professor of Orthopedic Surgery, University of Maryland; and Eleanor Wilkinson, Consultant in Nutrition, Children's Bureau, U. S. Department of Labor.

The proceedings of the conference, which will be printed, it is hoped, in the early fall, will add to the meager bibliography now available on convalescent care for children. These proceedings should be useful as teaching material in medical schools, and in the teaching units of services allied with medicine in the care of sick children and of children recovering from illness.

Committee Studying Convalescent Care

The calling of this conference was a milestone in the progress of a study of the needs of children for convalescent care and the facilities available for such care, which has been carried on for nearly a year and a half under the sponsorship of the National Society for Crippled Children and Adults by a committee of that society. The chairman of the committee is Dr. A. L. Van Horn, Director, Division of Health Services, United States Children's Bureau, who was also chairman of the conference at Hershey.

The committee has described the scope of its study as follows:

> The study on convalescent care for children is being conducted for the purpose of exploring the physical, mental, and social needs of children during the convalescent period; to define the optimum standards which should govern the provisions for care; and to determine the needs for the extension and improvement of convalescent facilities for the physically handicapped child in this country.

Participation Sought

The committee has sought to obtain information through several methods. Invitations to participate in the study were sent to the staffs of convalescent homes for children throughout the country in order that the practices already established in institutional programs for convalescent care might be learned. The majority of the convalescent homes accepted this invitation and have been extremely gracious in their sharing of information with the committee. It was realized early that the community also had an interest in such a project and for that reason help was sought from the Community Chests and Councils, Inc., in order to obtain a cross section of opinion from councils of social agencies as to what the needs of children in their geographic areas might be. The official State agencies that serve children through crippled children's programs were approached also, since it was believed that such official agencies not only were more closely in touch with the needs of rural children, but are actually at present the largest purchasers of convalescent care for children, through payments from Federal grants. Opinion as to need was also sought from the State affiliates of the National Society for Crippled Children and Adults.

Consultation has been sought from many individuals and agencies concerned with medical care for children, and representatives of the major medical-care agencies have met with the committee at its monthly meetings in Washington. Among the organizations that have shared their ideas with the committee are the United States Public Health Service and the National Research Council. The United States Children's Bureau has given consultation through members of its various divisions and this has demonstrated effectively what good results can be obtained when official and private agencies get together on matters that are a common concern.

Visits have been paid to many communities throughout the country by the director of the study so that the basic schedules might be supplemented by first-hand information on existing programs for convalescent care. The committee is interested in exploring programs that have been set up for children convalescing in their own homes or in foster homes under the auspices of child-placing agencies.

Tally of Needs

A tally of convalescent needs of individual children in a variety of diagnostic groups is to be made by a cross section of hospitals. The findings of the study are to be made available through a published report, and it is thought that these findings will be useful to the many citizen groups that are planning the development of convalescent care for children during the postwar period. Many community groups have crystallized their feeling of responsibility to the children of the Nation by preparing to build convalescent units in the postwar period, and it is largely due to the impetus of requests from such groups that the committee on convalescent care came into being. Heretofore facts on convalescent care for children have not been available in any concentrated form. The Commission on Hospital Care and other over-all planning groups also wish to consider the material gathered by the committee in their picture of total needs for medical care in the United States.

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Cerebral Palsy

Children With Cerebral Palsy; a report on the problem in California and a suggested program for their care. State Departments of Public Health and Education, San Francisco. December 1944.

A short general survey of the subject of cerebral palsy, adapted from a report by the Illinois Commission for Handicapped Children, is included in this report, as well as facts collected concerning the extent of the problem in California and a concrete plan for the care and education of these children in the State. It is emphasized that a successful State program for the care of children with cerebral palsy must include and coordinate the medical, surgical, neurological, educational, and social services. This report contains much of interest to all workers concerned with handicapped children.

Planning To Meet Poliomyelitis

By A. L. VAN HORN, M. D.
Director, Division of Health Services, U. S. Children's Bureau

Whether or not the season of 1945 brings an epidemic of poliomyelitis as serious as that of 1944, there are already an increased number of children with poliomyelitis in some States who need care and treatment.

Last year 19,271 cases of acute poliomyelitis were reported in the United States, more cases than were reported in any previous year since 1916. This year the number ran 50 percent higher than in 1944, up to the middle of June. By July 14, however, the total reported (1,677) was slightly below the 1944 figure for the same date (1,755), although far above normal, and reaching epidemic proportions in at least two States.

The State crippled children's agency is the agency legally responsible for carrying out the provisions of the Social Security Act for services "for children who are crippled or who are suffering from conditions which lead to crippling." Since acute poliomyelitis is a condition which leads to crippling and accounts for a substantial proportion of the children coming to the attention of the State agency who require orthopedic care, the official State crippled children's agency is responsible for seeing to it that children with acute poliomyelitis receive the care and treatment they need. In order to meet its broad responsibility, the State crippled children's agency must take leadership in overall planning for the care of these children so that all of them will get the best quality of care possible, regardless of whether or not the care is to be paid for, in whole or in part, by the official agency.

If children with poliomyelitis—as with all other children with physical handicaps—are to get the kinds of care and the quality of care they need, it is clear that all State and local community resources, public and private, must be used fully and appropriately. The importance of cooperation by the crippled children's agency with all agencies and organizations concerned with the care of crippled children was recognized in the original Social Security Act. With the growing interest of many citizen groups in one or another aspects of the care of children who are crippled or otherwise physically handicapped, the problem of cooperation and coordination has become increasingly important and increasingly complex. The Children's Bureau Advisory Committee on Services for Crippled Children, realizing the difficulty of the problem, has made this recommendation:

> The responsibility for the direction and administration of the over-all plan and program for the care of handicapped children should rest with the officially designated State and National agencies, and all efforts of voluntary agencies should fall within the pattern of adjuncts and aids to the official services.

This recommendation states a principle that is undoubtedly accepted by the official State crippled children's agencies. The implementation of this principle in the provision of care for the child with acute poliomyelitis, as in the provision of services for children with other handicapping conditions, will require careful thought and planning and a good deal of time and effort.

Certain aspects of advance planning for meeting a possible epidemic of poliomyelitis are not the primary responsibility of the crippled children's agency. Reporting of cases, recognition of an impending epidemic and other epidemiological studies, as well as measures for control of the epidemic, are the responsibility of the appropriate divisions within the State health department. These functions are distinct from the responsibility for services to children with poliomyelitis even if the crippled children's agency is in the health department. The crippled children's agency, or the crippled children's division of the health department, would of course need to be well-informed as to how these functions were being carried out. The services for which the crippled children's agency must plan are case finding, diagnostic services, medical and related care, hospital and convalescent care, and aftercare.

The Children's Bureau has been asked by a number of States for suggestions as to advance planning to meet epidemics of poliomyelitis. Some important points to be considered in planning for these services have been outlined by the Children's Bureau and sent to the State crippled children's agencies with a request for comments.

Texas Plan for Crippled Children's Services Approved

On June 7, 1945, the Chief of the Children's Bureau approved a plan for the remainder of the fiscal year 1945 for services to crippled children submitted by the Texas State Department of Health. This followed transfer of the responsibility for administration of the Texas program of services to crippled children from the State Department of Education to the State Department of Health. This transfer was brought about by an act of the State legislature, signed by the Governor May 16.

The approval of the State Department of Health plan for services to crippled children puts an end to the concern expressed by many in Texas as to whether Federal funds for care of crippled children would be discontinued following the hearing called by the Secretary of Labor and held on May 1. This hearing was for the purpose of determining whether there was failure on the part of the State Department of Education to comply substantially with any provisions required by title V, part 2, of the Social Security Act to be included in a State plan for services for crippled children. Testimony was presented at the hearing, and a full record was transmitted to the Secretary of Labor for review and action. However, because of the transfer of administrative responsibility from the State Department of Education to the State Department of Health, the Secretary of Labor has closed the case without further action and on June 5 so notified the Governor of Texas and the State Superintendent, Department of Education.

San Antonio Fights Baby Diarrhea

An educational campaign to combat diarrhea in babies is being conducted by the San Antonio (Tex.) Health Department through a permanent council on diarrhea control composed of representatives of the health department and of 28 local social-service agencies and civic groups.

Last year in San Antonio almost 250 children under 2 years of age died of diarrhea, most of them during May, June, and July. This year the city's effort to prevent such deaths began in the early spring. At that time, volunteer workers—many of them mothers—who had been trained under the direction of the diarrhea - control council, began house-to-house educational visiting, each such visit to be followed by a visit by a health-department sanitarian. At the same time teachers in the elementary schools began instructing their pupils in methods of preventing diarrhea, using material prepared for the purpose by the health department. Printed material was also given the pupils to take home to their parents. Because San Antonio has a large Spanish-speaking population the material for the pupils was prepared in both English and Spanish.

For Mothers—An Illustrated Leaflet

An illustrated leaflet, both in English and in Spanish, was prepared by the health department for distribution to mothers. This reads as follows:

> "Diarrhea (summer complaint) is carried by dirty hands, dirty food, dirty bottles, dirty nipples, and flies. Keep *your* baby from having diarrhea.
>
> "1. Baby must be in bed alone.
>
> "2. Cover bed with mosquito netting.
>
> "3. Soiled diapers must be kept covered.
>
> "4. Good care will keep your baby well.
>
> "Boil all cooking utensils, all bottles and nipples, all drinking water for the baby.
>
> "Wash all fruit, such as apples, oranges, and bananas, before giving it to a baby.
>
> "If your baby does get diarrhea, take him to your doctor immediately, or to a hospital clinic."

When a volunteer worker visits a home, she gives the mother one of these leaflets and explains each point.

So that nurses and sanitarians may know where they are needed most in protecting babies from diarrhea, each volunteer worker that visits a home to instruct the mother reports to the health department upon home conditions such as the number of children under 2 years of age, whether there are screens to keep out flies, whether there is any way to keep milk cold, how garbage and waste water are disposed of, kind of toilet, and whether or not mother has a pan for sterilizing nursing bottles, a covered bucket for soiled diapers, and mosquito netting. A committee of the diarrhea council endeavors to make these necessities available to families that are without them. Through the Junior Chamber of Commerce a revolving fund of $500 has been set up to purchase such materials.

For Health Workers—"The Key to Health"

Health-department sanitarians who visit homes after receiving the reports of the volunteer workers check on possible places where flies breed, such as uncovered garbage cans, and try to obtain the cooperation of the owner of the house in correcting such conditions.

Each volunteer worker and health-department sanitarian wears a badge showing a picture of a key and the words: "For health. This worker carries the key to health. Ask for it." On the reverse of the badge are the same words in Spanish.

An educational motion picture prepared for the campaign, with narration both in Spanish and in English, is shown at local theaters to teach parents what they can do to prevent diarrhea in their babies. Speakers to address groups desiring information on diarrhea prevention have been arranged for by the council, and radio programs are presented.

For Sick Babies—Proper Care

When a baby is found by a worker to have diarrhea, the case is referred promptly to a private physician or a hospital clinic, through the work of the council's sick-baby committee and nursing committee. The nursing committee, which is composed of all the public-health nurses on the staff of the city health department, follows up each case after the baby is sent home from a hospital clinic, to see that he gets proper care.

In each of the 11 permanent well-baby conferences held weekly in the city the nurses teach control of infant diarrhea through individual conferences with each mother and through group conferences. At these conferences a method of sterilizing the baby's milk mixture is demonstrated using a sterilizer improvised from a 5-quart oil can, in which the filled bottles are boiled and then set aside to be used in the next 24 hours. Covering the baby's bed with mosquito netting is demonstrated. The importance of general cleanliness is discussed and is correlated with everything that is done. The value of breast feeding as compared with bottle feeding in preventing diarrhea is stressed.

Further information with regard to the campaign may be had by writing to Dr. Lewis C. Robbins, Director of Public Health, 128 West Commerce Street, San Antonio 5, Texas.

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Children's Bureau Advocates Justice to All Groups

Soon after the War Department's order lifting the ban on residence of persons of Japanese ancestry in Oregon, Washington, and California became effective (Jan. 2, 1945), the Committee on American Principles for Fair Play asked the Children's Bureau for a statement of its policy regarding race, color, and creed. The response of the Chief of the Children's Bureau was as follows:

> The Children's Bureau consistently advocates justice to all people in all aspects of life regardless of race, color, or creed, and especially equal access of all children to all services and opportunities promoting their health, education, and welfare. Administration of all services for which Children's Bureau is responsible, including maternal and child health, emergency maternity and infant care, crippled children, and child welfare, is based on this principle. We are particularly interested in opportunities that will be afforded to loyal persons of Japanese ancestry returning to their former homes and communities, or relocating elsewhere. The Bureau will give all possible cooperation in working out plans for mothers and children.

Problems of Children in Liberated Countries

A committee of the National Commission on Children in Wartime, appointed to consider problems of children in liberated countries, met on June 11, 1945, to consider these urgent problems, including displaced children and other children in need of rehabilitation, and conferred with representatives of the United Nations Relief and Rehabilitation Administration.

The committee adopted a statement of principles and directed a subcommittee to confer with the Hon. Herbert H. Lehman, Director General of UNRRA. The members of the subcommittee were: Leonard W. Mayo, chairman; Leona Baumgartner, M.D., Director, Bureau of Child Hygiene, Department of Health, New York City; Maxwell Hahn, Field Foundation; J. Milton Patterson, Director, Maryland State Department of Welfare; Katharine F. Lenroot, Chief, Children's Bureau.

The statement is as follows:

1. The committee of the National Commission on Children in Wartime, appointed to consider problems of children in liberated countries, desires to express confidence in the soundness of the general approach of UNRRA to the complex problems which confront it and appreciation of the substantial progress already made in such countries as Greece, Italy, and Jugoslavia in the face of inevitable political and technical obstacles.

2. The committee calls attention to the fact that the basic international agreements which led to the creation of UNRRA specifically provided that all foreign-relief programs operated in a given country be carried out with the agreement and cooperation of UNRRA and urges that this policy be kept clearly in mind.

Photograph by United Nations Relief and Rehabilitation Administration

SAFE NOW from bombs, the war for these little Yugoslavs, getting off a train at Suez, and for many thousands like them, will not be over until they are home.

3. The committee emphasizes the importance of carrying out all measures relating to the care of displaced children under the direction of UNRRA with the counsel of qualified child health and social workers and in accordance with policies laid down by such authorities. These policies should be directed toward alleviating the emotional as well as the physical stresses under which these children suffer.

4. The committee urges that identification of displaced children should take precedence in programs for their care, in order that it may be possible promptly to restore them to their own families or relatives wherever possible. Policies should be developed immediately by the highest Army authorities and UNRRA in regard to the services to be rendered by UNRRA in dealing with displaced children in territories under military control.

5. With regard to urgent food needs of children in liberated countries, the committee makes the following recommendations:

> The attention of the American people should be called to the deplorable state of malnutrition now existing in many countries of Europe, and to the fact that the coming winter promises from this standpoint to be the most menacing of the war. This crisis cannot possibly be met without exports of meat and milk products and other protected foods far in excess of those now permitted under Government regulations. The regulations are based on an inadequate faith in the willingness of the American people to make minor sacrifices in the cause of humanity. This willingness, publicly expressed, would, the committee believes, lead to modification of the regulations.

As President Truman has said, "Beyond our tremendous military requirements lies the task of working with other nations to help liberated peoples regain their strength and rebuild their countries. There can be no lasting peace in a hungry world. We Americans must do our part to help swell the Nation's food supply."

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The Minister of Health, Great Britain, is inviting all local authorities with experience in billeting under the Government evacuation plan to draw up a list of householders who have successfully looked after evacuated children and who may be willing to act as foster parents to other children. The Ministry feels that the experience gained during evacuations can be used to the advantage of orphans and other children who become the responsibility of local authorities or voluntary organizations. *British Information Service: Information Division Circular No. 56, New York, Jan. 10, 1945.*

BOOK NOTE

Food for the World. Edited by Theodore W. Schultz. University of Chicago Press, 1945. 353 pp. $3.75.

This book consists of the 23 papers and related discussion that made up the program of the Twentieth Institute of the Norman Wait Harris Memorial Foundation, held at the University of Chicago September 4 to 8, 1944. Under the theme, "Food in International Relations," the several sections deal with "The Food Movement," "Population," "Nutrition," "Food Supplies," "International Relations," and "Consequences and Policy." Although most of the authors and discussants are Americans, many of them have been associated with international activities in the fields of agriculture, population studies, food economics, or nutrition. There are stimulating clashes of opinion on many points, but no challenge of the fundamental statement from the United Nations Conference on Food and Agriculture that "the first cause of hunger and malnutrition is poverty." Although the reader is not likely to be equally interested in all these facets of the international food problem, he is almost sure to be rewarded both by the competent treatment of his special concerns and by the brilliant essays on general policy.

CHILD-WELFARE WORKERS ARE COUNTED

For the first time national figures on the number of public child-welfare workers are available

By EDWARD E. SCHWARTZ

Director, Division of Statistical Research, U S. Children's Bureau.

One of the most critical problems confronting administrators of public child-welfare programs during the war has been the personnel situation. To provide base lines for measuring changes in this situation, Nation-wide and in the various States, during the remainder of the war period and afterward, the Children's Bureau has recently issued comprehensive statistical data on personnel in public welfare agencies providing services (other than institutional) to children at the beginning of the fiscal year 1944-45, based on information received from 47 States, Alaska, the District of Columbia, Hawaii, and Puerto Rico.[1]

More than 3,600 workers were reported by the 51 jurisdictions as employed in providing social services to children in their own homes and elsewhere under public-welfare auspices. This figure may seem impressive, especially since it excludes workers attached to child-caring institutions. The total number of workers also may seem large in comparison with previous national figures, for previous figures were limited to workers paid in whole or in part from Federal funds, for child-welfare services under the Social Security Act, and in 1944 more than four-fifths of all workers in public child-welfare programs were paid entirely from State and local funds.

Professional personnel in public welfare agencies providing noninstitutional services to children in the United States, July 31, 1944[1]

Classification of position	Total	Paid entirely from State and local funds	Paid in whole or in part from Federal child-welfare-service funds
Total	3,637	2,986	641
Workers providing service directly to children	2,929	2,485	444
Full-time child-welfare workers	1,734	1,348	386
Part-time child-welfare workers and other workers	1,195	1,137	58
Supervisors	664	467	197
Full-time	478	302	176
Part-time	186	165	21
Specialists	44	34	10

[1]Includes Alaska, the District of Columbia, Hawaii, Puerto Rico, and all States except Utah, which is not receiving Federal child-welfare-service funds.

Less than half of the 3,600 workers reported were full-time child-welfare workers. Of 2,900 workers serving children directly, close to 1,200 gave only part of their time to services to children. About 700 of the total were supervisors (including administrators and consultants), and "specialists," a term which includes psychologists, home economists, statisticians, and other personnel who are not social workers, but who function in an advisory and service capacity to the social-work staff or provide specialized services to children.

The figure for workers giving part time to providing services to children includes not only actual part-time employees, but an even larger number of full-time employees with responsibility for public assistance or other types of welfare programs. (The data are known to be incomplete for the workers in this latter group, but are substantially complete for full-time workers.)

Of the 3,600 workers providing services to children only about 1,750, therefore, were full-time child-welfare workers serving children directly. If the 1944 population of the United States under the age of 21 is estimated as 49,000,000, there was in that year 1 full-time noninstitutional child-welfare worker for every 28,000 children in the country.

Concentration of Workers

These relatively few full-time child-welfare workers were concentrated in a few States, more than half of them (980) in 8 States—New York, Massachusetts, Minnesota, Indiana, Washington, Ohio, Illinois, and Connecticut. The number of workers in these States ranged from 404 to 59. At the other extreme, 32 States had fewer than 25 full-time child-welfare workers each.

The fact that more money from State and local funds is available for employment of child-welfare workers in States with large urban populations contributes to the concentration of workers in such States, and in the urban areas of such States. Of the 1,350 full-time child-welfare workers who were paid entirely from State and local funds, 70 percent were employed in the 8 States listed in the previous paragraph. Moreover, 53 percent of these 1,350 full-time workers were in 58 urban counties (counties in which were located cities of 100,000 or more population). In contrast, only 7 percent of the full-time workers who were paid in whole or in part from funds for child-welfare services under the Social Security Act were located in urban areas. (Federal funds were used to pay, in whole or in part, the salaries of 27 full-time child-welfare workers in critical areas severely affected by war conditions.)

Rural Needs Stressed

Under the provisions of title V, part 3, of the Social Security Act (Child-Welfare Services) Federal funds are to be used to enable the United States through the Children's Bureau to cooperate with State public-welfare agencies in establishing, strengthening, and extending child-welfare services, especially in predominantly rural areas. The use of Federal funds under this portion of the act to provide workers in rural areas tends, within the limits of the funds made available, to bring about a wider distribution of workers throughout the United States. Although workers paid in whole or in part from Federal funds constituted only 18 percent of all child-welfare workers, the sole, or major, group of public child-welfare personnel in a number of States consisted of workers so paid. This was true in, for example, Alaska, Arkansas, Idaho, Nevada, Oklahoma, South Dakota, and Texas.

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[1]Personnel in Public Welfare Agencies Providing Noninstitutional Services to Children in the United States, July 31, 1944. Children's Bureau, U. S. Department of Labor, Washington, 1945. Mimeographed.

The paucity of child-welfare staff in large sections of the United States is indicated by the fact that only 550 (18 percent) of the more than 3,100 counties and other minor political subdivisions in the United States, have one or more workers devoting full time to child-welfare services. In the counties not having a full-time child-welfare worker, the time of one worker must be shared among two or more counties, or reliance must be placed on a worker who is giving only part time to work for children. Other counties must depend on whatever service can be provided by staff attached to the State welfare department.

Few Negro Child-Welfare Workers Reported

Little utilization of Negro workers in building up child-welfare staffs is indicated by the fact that of the 49 States reporting information on the race of child-welfare workers only 15 States employed any nonwhite workers. Two-thirds of the 117 nonwhite workers reported were employed in 5 States, Illinois, Indiana, Ohio, Virginia, and the District of Columbia.

Lag in Salary Increases

The salary scale, of course, is one of the most important factors affecting the supply and distribution of child-welfare workers. The salaries of workers in rural areas are appreciably lower than those of workers in urban areas. The median salary for all the full-time child-welfare workers on July 31, 1944, was $1,985. The median salary of the workers in urban areas was $2,101, or 10 percent higher than the median for workers in rural areas, $1,907.

Data available only for workers paid in whole or in part from Federal funds showed an increase in median salary of less than 5 percent from June 1943 to July 1944—a 13-month period characterized by rapidly rising living costs and a tight labor market. That salaries of child-welfare workers had, in general, increased in the early war period is shown in a recent report by the Russell Sage Foundation,[2] but it cannot be assumed that by June 1943 they had risen to such a level that further general increases in 1943-44 were limited by the "Little Steel Formula."

The higher qualifications required in general for workers giving full time to child-welfare services than for those who divide their time between child-welfare services and other welfare programs is reflected in salary differentials. Whereas the median salary rate for full-time case workers was $1,985, that for part-time case workers was $1,648. Full-time child-welfare case supervisors have a median salary rate of $2,608, compared with $2,171 for supervisors giving only part time to child-welfare services.

The extreme instability of the situation with regard to child-welfare personnel under war conditions is evidenced by the fact that on July 31, 1944, the proportion of all the workers who had been in their positions less than 1 year was more than one-third. Statistics available only for workers paid in whole or in part from Federal funds show that in June 1943, 53 percent of such workers had been employed in their positions less than 1 year, and in July 1944 this percentage was down to 47. These data provide a general indication that there was less staff change in 1944 than in 1943.

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[2] Hurlin, Ralph: The Recent Trend of Salaries in Child-Welfare Agencies. Russell Sage Foundation, New York, 1944. 14 pp.

Children's Bureau Terminates Responsibility for Social-Statistics Project

The Children's Bureau terminated its responsibility for the operation of the social-statistics project on June 30, 1945, because of inability to obtain increased funds for strengthening and expanding the program. It was believed that continuing Federal responsibility on the present limited basis was not justified. Through the project, data have been made available on the volume and cost of over 20 types of health and welfare services in more than 40 urban areas.

The social-statistics project was undertaken originally in 1928 as a joint responsibility of the Local Community Research Committee of the University of Chicago and the Association of Community Chests and Councils. The Children's Bureau took over the project in 1930 when the Bureau was one of the few agencies in the Federal Government to have a well-developed social-welfare program. The value of the project for local community planning, especially as related to child health and welfare, was recognized, and it was hoped that the original coverage of 29 urban areas would be expanded to include all urban areas in the country.

Lack of sufficient funds for the operation of the social-statistics project has resulted in the inability to increase the number of participating areas as originally planned (the areas now included do not constitute a representative sample of all urban areas in the country), and to provide field service in relation to the work of the project. The lack of field service is a major deficiency that limits the usefulness of the project locally and greatly limits its value for national information and planning. Without field service it has been impossible to consult with areas on the local use of the reported data or to obtain the detailed knowledge of local health and welfare developments which is essential for interpreting the reported data and for revising report forms and instructions. It has not been possible to adapt report forms and instructions to changing conditions in fields of service covered by the project.

The Children's Bureau will continue its interest in statistics on local child health and welfare programs. The Bureau's responsibility for operating the various grant-in-aid programs has resulted in the development of reporting relationships between the Children's Bureau and the State agencies responsible for administering the programs. The emphasis of these Federal-State relationships is on obtaining adequate

Nation-wide statistics through State agencies and on encouraging and assisting these agencies in developing programs of research and statistics in child health and welfare on State and local levels. The Children's Bureau has provided, and will continue to provide, all possible assistance to State agencies in the development of these programs with the recognition that local reporting and research are basic to State-wide and Nation-wide statistics. In this way it will be possible to continue to meet to a limited extent the needs of the Bureau, of State agencies, and of local areas for current reports on the child health and welfare services which are provided, as well as for research on the need for service, nature of service, and results of service.

Although reports will no longer be obtained by the Children's Bureau through the social statistics project, many of the areas that have been participating in the project have indicated a strong interest in continuing it locally. Community Chests and Councils, Inc., will provide assistance to these communities until other plans can be made for national supervision of the project.

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Emergency Maternity and Infant-Care Program

- **Nearly 850,000 cases authorized**
- **One application only required**
- **Ruling on prepaid service benefits**

Through May 31, 1945, a total of 845,969 authorizations have been made for mothers and infants to receive medical, hospital, and nursing care under the Emergency Maternity and Infant Care program administered by State health departments under plans approved by the Children's Bureau. Authorized by Congress on March 18, 1943, this program has been in full operation since March 1944 in all 48 States, the District of Columbia, Alaska, Hawaii, and Puerto Rico.

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Under a new administrative policy for this program, the wife of a serviceman may make application for care for her unborn baby at the same time she applies for obstetric care for herself. Formerly it was required for wives to make separate application for their babies after birth.

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Several State health-agency officials have requested that an interpretive policy statement be issued to clarify the recommendations of the Children's Bureau with reference to use by recipients of emergency maternity and infant care of medical and/or hospital prepaid service benefits under voluntary plans.

The basic policy governing this question is given in Emergency Maternity and Infant-Care Information Circular No. 1 (Revised March 1945), Section II, 9, which reads as follows:

> Physicians' services will not be authorized if the patient or someone in behalf of the patient is to pay for hospital care; and hospital care will not be authorized if the patient or someone in behalf of the patient is to pay the physician for medical care.

In order to clarify the question regarding the use of medical and/or hospital service benefits by recipients under the emergency maternity and infant-care program the following policy statement is issued, effective July 1, 1945:

> ***Prepaid medical and/or hospital service benefits for maternity or infant care are considered as payments made in behalf of the patient; however, cash-indemnity insurance benefits paid to the insured are not considered as payments made in behalf of the patient.***

This policy statement, it is believed, is consistent with the original intent of Section II, 9, and is in conformity with the basic philosophy of the emergency maternity and infant-care program, that services are to be made available to all eligible wives and infants on the same basis and without regard to their economic resources. Use of prepaid service benefits for maternity and infant care would greatly reduce services available to servicemen's dependents for other illnesses, because many prepaid and/or hospital benefit contracts limit the care for which payment may be made in a given period of time.

BOOK NOTES

IT'S A WISE PARENT, by Mollie Stevens Smart and Russell Cook Smart. Charles Scribner's Sons, New York, 1944. 206 pp. $2.

"If we can help other young parents to enjoy themselves *as parents,* to see and appreciate the aspects of parenthood that are fun, and not be weighed down by their grave responsibilities, we will be very pleased," say the authors of this book in their preface. And they do a good job of it, too. Although the book is not what might be called a basic one—it is not a complete guide—it is delightful supplementary reading from which fathers and mothers can profit through developing sound attitudes and practical techniques. Because the whole span of childhood is discussed in a small space, the book is necessarily sketchy at some points; this weakness would have been compensated for if the authors had extended their annotated bibliography to include a more complete indication of the sources of information that parents need. As far as the text itself goes, it is thought-provoking as well as entertaining, and it does particularly well in showing how fathers as well as mothers can be practicing parents.

The authors, who are parents as well as child psychologists, suggest that it's a wise parent who knows not only his own child but himself or herself. Although understanding yourself may not banish all your troubles, they say, it may enable you to create the relaxed atmosphere in which the parents and children live together most happily.

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MICROBES THAT CRIPPLE, written and illustrated under the direction of Edward L. Compere, M. D., by T. Arthur Turner, National Society for Crippled Children, Elyria, Ohio, 1944. 241 pp. $2.50.

This is a book for the intelligent layman. According to the foreword, it "has been put together on the theory that there are a certain number of people in the country who, though they have neither the time nor the inclination to search through a vast and scattered technical literature, want to acquire a valid and organized idea of the relationship of pathogenic microorganisms to human deformity."

TRAIN YOUNG FARM WORKERS FOR SAFETY

Accidents will happen to city youngsters who work on farms, even under the supposedly best-regulated programs. National Farm Safety Week, being observed this year during the week of July 22-28, is a good time for persons responsible for emergency farm-labor programs to remind themselves of the continued need for teaching young workers how to keep from getting hurt.

The need for such instruction is brought to mind whenever accidents to young workers are reported. One such report, on insured boys and girls working under emergency farm-labor programs[1] lists the death in New York State of a 14-year-old boy through a tractor accident that happened while he was at work. It is well known that tractors and other machinery form a major cause of accidental deaths among farm workers, and also that the wartime shortage of new machines and of skilled repairmen creates an even greater machine hazard. Moreover, much machinery now in use on farms is without adequate guards, is worn out, or is obsolete, and is therefore especially dangerous.

The same report states that a 15-year-old boy in Vermont lost the sight of one eye after a foreign body lodged in it. This accident also occurred while the boy was working.

One 15-year-old boy worker in Missouri suffered a badly injured back in a truck accident, and the cost of medical and hospital care amounted to more than $200. Accidents occurring during transportation of farm workers in trucks are often the cause of serious and even fatal injuries.

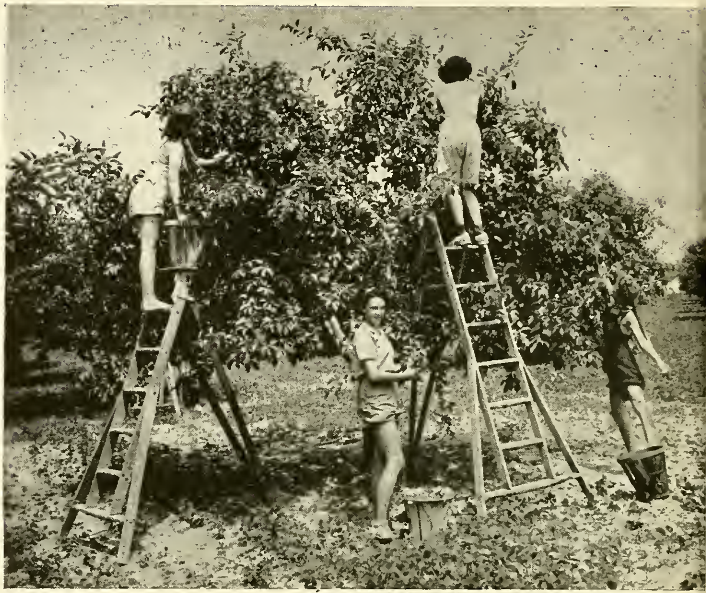
A less serious type of injury is ivy poisoning. But 12 boys and girls with cases of poison ivy or poison oak required medical care costing $384, an average of $32 a case. These high costs may have been partly due to the distances that the doctors had to travel to reach the patients, as in some areas it is customary for the doctor to charge a set rate per mile in addition to his fee. But the poison-ivy and poison-oak hazard is worth remembering when supervisors are reminding youngsters that working clothes should cover arms and legs. Experienced farm workers cover their arms and legs, not only to avoid ivy poisoning, but also to avoid excessive exposure to the sun. (In the picture on this page, two of the girls have not only bare legs, but bare arms and shoulders.)

The importance of proper clothing for protection is suggested also by two cases of foot injury. A Colorado boy, 15 years old, stepped on a nail while at work and had to be treated by a physician; likewise an Ohio boy of 10. Of course, every farm worker should wear shoes while working. (In this connection, note the girl on the left in the picture. She is barefooted, and therefore is liable to foot injury.)

Ladder accidents were responsible for injuries to two boys of 13 in the State of Washington. One of these fell from a ladder while working; one jumped. Both needed medical attention. (Ladders of a safe type, as shown in the picture on this page, help in preventing falls. Safety instruction will help to keep youngsters from jumping off ladders.)

All the children and young people who suffered the injuries listed in the foregoing paragraphs were covered by personal accident insurance policies that provided for medical and hospital care plus a given amount of cash in the event of death or loss of a member. But accident insurance does not bring back a life or an eye, nor does it make up for pain.

However, it must be remembered that many boys and girls who are in-



Photograph by United States Department of Agriculture

EVEN THE WORST SHORTAGE of farm labor is no justification for taking chances with the safety and health of young workers. The little girl on the left is too young to be working atop a tall ladder. Her basket, in a very unsafe position, may topple and carry her with it to the ground. Barefooted, she runs risks of injury and infection.

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[1] Botts, Ralph R.: Experience of 21 Reporting Companies With the Victory Farm Volunteer and Farm Cadet Victory Corps Accident Policies in 1944 (including Insurance Proposals for 1945). U. S. Department of Agriculture, Bureau of Agricultural Economics, Washington, 1945. 5 pp. Mimeographed.

jured at work have not the benefit of insurance, and sometimes the cost of medical and hospital care uses up all the money they receive for their summer's work, or more.

It is hoped that this summer more of the young workers will be trained to give due regard to their health and safety while at work. The motto of the boys and girls, of their supervisors, and of their employers should be: No avoidable accidents or illnesses this season.

But in any event, these young workers should also be protected financially by workmen's compensation insurance to cover accidents at work, by insurance during transportation, or by some other means of providing for their expenses in case of accident.

Safety Check List for Young Farm Workers

The following check list has been prepared for the use of young farm workers by the National Safety Council. For further information write to the National Safety Council, 20 North Wacker Drive, Chicago 6.

I WATCH MY HEALTH

I had a medical check-up. The doctor says I'm fit for the job. ☐

I get at least 8 hours of sleep every night. ☐

I wear comfortable shoes, a broad-brimmed hat and light-colored clothes that fit well and cover my arms and legs. ☐

I expose my arms and shoulders gradually and for short periods when I want to develop a suntan. ☐

I take no chances with infection. I get first aid for even the smallest cuts and scratches. ☐

I USE CARE ON LADDERS

I make sure that ladders are strong and set solidly at the proper angle. ☐

I face the ladder when climbing and hold on with both hands. ☐

I never carry things in my hands while climbing. ☐

I keep myself well balanced at all times. ☐

I avoid overreaching by moving the ladder when necessary. ☐

I EAT THE RIGHT FOOD

I eat a good breakfast, carry a hearty lunch. ☐

I carry a small midmorning and midafternoon snack (like some fruit or cookies) when hours are long and the work is hard. ☐

I drink plenty of clean cool (not ice cold) water, but do not drink water from ponds, creeks, or open wells. ☐

I eat extra salt during hot weather (unless I have diabetes or heart trouble) to replace the salt lost in perspiration. ☐

I HANDLE TOOLS AND MACHINERY WITH RESPECT

I always cut away from myself when using a knife or other sharp tools. ☐

I never run with sharp tools in my hand or mouth. ☐

I use the right tool for each job and make sure that I know exactly how to use it. ☐

I never wear ties, loose clothes, or floppy gloves around moving machinery. ☐

I never unclog, oil, or adjust a machine unless it is completely stopped. ☐

I USE MUSCLES CORRECTLY

I take it easy the first few days on the job in order to work myself into condition gradually. ☐

I bend my knees instead of my back when working on low jobs. ☐

I keep my back straight when lifting. ☐

I don't show off. I call for help when the job is too heavy. ☐

I learn to do each job efficiently without lost motion. ☐

I AM ORDERLY WHEN RIDING TRUCKS OR BUSSES

I follow directions of the driver or supervisor carefully. ☐

I get on and off the truck only when it is standing still. ☐

I never hang on the side of the truck or ride on the running boards. ☐

I don't scuffle or engage in horseplay while riding. ☐

I never stick my head, arms, or legs out of bus windows or beyond the edge of truck bodies. ☐

Court Action in Child-Labor Cases

Taking employers to court is a last resort in enforcing child-labor provisions of the Fair Labor Standards Act

NOTE.—Most employers really desire to comply with child-labor standards of the Fair Labor Standards Act, and for these, even when violations are found on an inspection, a warning from the Children's Bureau against further violations is usually sufficient. The provisions of the law are explained to the employer when the inspection is made. If he has failed to take advantage of the protection we can give him through age certificates he is urged to obtain them for all minors he employs. He is informed of any child-labor violations found, and is told where certificates may be obtained. Compliance is thus gained in the vast majority of cases through educational means.

Some employers, however, are willing to take the risk involved in employing illegal child labor. For these, legal action is the only preventive against future violations. In addition, there are employers who in violating the act indicate such gross negligence or careless disregard for its requirements that legal action is necessary.

The following cases are examples of willful and flagrant violation, for which the prosecutions provided by the act were felt to be necessary. These violations include cases where children under 16 were employed contrary to the law's basic 16-year minimum-age provision and also cases where minors under 18 were employed contrary to hazardous-occupations orders issued under the act. The court in every instance found the defendants guilty and imposed fines.

Canneries

After acknowledging that he had hired minors under 16 during the 1942 canning season, the president of a vegetable cannery boasted that he could employ under-age minors again in 1943 by carrying them on the payroll under assumed names. The attitude of this employer, whose cannery had been previously inspected four times and who was secretary-treasurer of another cannery that had been previously inspected three times, led to an investigation of conditions in both plants. It was found that during the 1943 canning season 14 under-age minors had been employed at one of these canneries as well as 1 minor 17 years old who was employed as a motor-vehicle driver in violation of the hazardous-occupations order that sets a minimum age of 18 years for this occupation. The other cannery had employed 17 children under 16 years of age

When interviewed at the time of the investigation, the employer denied any knowledge of the employment of under-age minors, although many of them, according to their statements, had been hired by him, and at the time of hiring they had told him that they were only 14 or 15 years of age. The employer's social-security records, moreover, indicated the correct age of many of the minors.

The employer had been advised repeatedly of the protection afforded by age certificates, but he had made no attempt to obtain proof of age for his young workers.

According to their signed statements, these children worked extremely long hours, especially during the pea-canning season, when some worked from 7 a.m. until 3 or 4 a.m. the following day. Some of them, moreover, had heavy and hazardous jobs.

In each of these cases the individual defendant was acquitted, but the corporate defendant was found guilty and was fined $600, or a total of $1,200 for the two plants.

An inspection in October 1943 disclosed illegal employment of minors during the 1943 canning season by a corporation whose canneries had been previously inspected —once in 1939 and twice in 1940. A number of the under-age minors had been hired by the assistant superintendent, who was familiar with the child-labor provisions of the act.

The firm appeared to have made no attempt to obtain age or employment certificates for any of the minors, some of whom were hired even after they had informed the employer that they were under the legal minimum age of 16 years. One of the minors, a very small, thin lad, 13 years old, wrote a signed statement as follows: "I was hired by Mr. ———, who knew me personally and knew that I was 13 years of age." This child also stated that he usually worked 10 hours or more a day and that one night he went to work at 9 p.m., worked until 7 a.m. the next day, went home and ate breakfast, returned at 9 a.m., and worked until 12 noon, a total of 13 hours.

Further evidence that the employer's disregard of the law was not unintentional is given in a written statement from an official of a local board of education.

> The superintendent of the ——— Company, Mr. ———, has been contacted or visited practically every school year regarding the employment of school children. I have left with him a copy of the school law at different times. Mr. ——— has been advised not to employ children of school age [under 16] in the canning factory.

The corporation pleaded guilty to eight counts of the indictment; and the court imposed a fine of $320 and costs.

A luggage-manufacturing establishment

A company engaged in manufacturing luggage was found violating child-labor provisions of the Fair Labor Standards Act in February 1943, when the establishment was inspected for the second time. Six minors were illegally employed, three in violation of the basic 16-year minimum age established for general employment and three in violation of the hazardous-occupations order establishing a minimum age of 18 years for employment in operation of power-driven woodworking machines. There were also 25 minors claiming to be 16 or 17 years of age who were employed without age certificates on file. The inspector explained the procedure for obtaining age certificates, and the employer agreed to obtain the necessary certificates at once. A warning letter was also written by the Children's Bureau to the employer advising him to protect himself from unintentional violation of the act by obtaining age or employment certificates.

Subsequent inspections in February and May 1944 revealed continued and flagrant violations, in spite of the fact that the employer had repeatedly agreed to obtain documentary proof of the ages of employed minors in order to comply with the child-labor provisions of the act. Even after acknowledging that minors often falsified their ages, and after each promise to comply with the law, the employer hired under-age minors, usually without requiring any documentary proof of age.

A 15-year-old girl, employed in violation of the basic 16-year-old minimum age, reported:

> I was employed by the ——— Manufacturing Company on May 2, 1944, by ———, personnel manager. I gave my date of birth on my application as June 27, 1926. I was actually born June 27, 1928, and was only 15 years old when employed. I was not asked to furnish proof of age at any time during my employment and am still employed at the present time. My work consists of covering luggage.

A 16-year-old boy, employed contrary to the hazardous-occupations order setting an 18-year minimum age for work as driver or helper on motor vehicles, reported:

> I started to work on my present job about September 15, 1943. I work in the shipping department. I load trucks that come in on various truck lines. I ride down to Fifteenth and ——— on the truck and unload lumber from box cars. Sometimes I go down to the box car with a load of luggage and help load the box car. I haul lumber or luggage all week at times, and at times a week will go by when I do all my work in the plant. I unload all types of lumber. There is no regularity to my trips on the truck. One day about 2 weeks ago I worked 17½ hours in 1 day unloading lumber from the car and riding to the plant on the truck where I unloaded it again. Robert ———, who also works at the plant, drives the truck sometimes.

This company was charged on 19 separate counts, 15 involving violations of the basic 16-year minimum age, and 4 involving violations of the 18-year minimum age established for hazardous occupations. An example of the latter group was a boy of 16 whose work was cleaning and oiling machinery, and who also operated a resaw and was off bearer from a circular saw. The court declared that "any concern doing Government business should cooperate with Government agencies. The information here shows that even after the defendant company had been warned, it continued to employ minors."

The court fined the firm $50 on each of 15 counts involving violations of the basic 16-year minimum age and $750 on each of 4 counts involving violations of the 18-year minimum age for hazardous occupations, the total fine amounting to $3,750. The United States district attorney's office, however, joined the defense attorney in a plea that the penalty be mitigated, and after reconsideration, the court fixed the total fine at $2,500.

A woodworking plant

Violations of the hazardous-occupations order that sets a minimum age of 18 years for work on power-driven woodworking machines were revealed in an inspection in 1944 of an establishment engaged in manufacturing various sizes of lumber, as well as finished lumber products such as card tables and ironing boards. A total of 18 minors were employed illegally. Twelve minors, six of whom were under 16 years of age, were employed on power-driven woodworking machines, and six were employed contrary to the basic 16-year minimum-age standard set by the act for general employment.

To cite some examples of occupations at which children were employed: A 14-year-old boy operated a circular saw, a 14-year-old girl was removing lumber directly from circular saws, a 14-year-old girl was off bearer directly from a ripsaw, and a 15-year-old girl was a helper off bearing directly from a cut-off saw.

During a previous inspection in 1940, and again in June 1944, when the violations were found, complete information had been given company officials regarding the child-labor provisions of the act and the hazardous-occupations orders applicable to their industry. In spite of this, a 17-year-old girl was hired in July 1944—a month after the last inspection—to work at a hazardous woodworking machine. She was not asked for any proof of age, and she was still working at this occupation in August 1944.

Criminal action was brought against the company, and a fine of $500 was imposed.

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BOOK NOTE

DOUBLE AND TREBLE LIABILITY CASES OF ILLEGALLY EMPLOYED MINORS AMONG COMPENSABLE WORKMEN'S COMPENSATION CASES SETTLED IN 1944. Statistical Release No. 3159. Industrial Commission of Wisconsin, Madison, 1945. 11 pp.

The Industrial Commission of Wisconsin has recently issued a statistical report concerning illegally employed minors to whom double or treble indemnity was paid under the provisions of the Wisconsin Workmen's Compensation Act. The report shows that cases of this nature have increased each year since 1940—from 37 in that year to a peak of 257 in 1944. The latter figure represents 20 percent of the total of 1,297 cases of injuries to minors of permit age that were settled in 1944.

The Wisconsin Workmen's Compensation Act provides that increased compensation be paid to minors suffering a compensable injury while illegally employed. In general, double indemnity is payable when the employer has failed to obtain a child-labor permit for the child, and treble indemnity is due when the employer has "required, suffered, or permitted" the minor to work in an employment prohibited to a child of his age. The additional compensation must be paid by the employer himself, not by the insurance company.

Go-to-School Drives Get Under Way

This year communities are gearing for Go-to-School drives more vigorously, even, than last year when they put a stop in many places to the drastic falling-off of high-school enrollment.

Parents, unions, employers, and civic leaders are concerned, and rightly so, about what will happen to our teen-agers when peace is won.

During war, they have done yeoman service, speeding up—even giving up school so that they can help us get on with our business. With peace, they will have to take over vastly more difficult and responsible duties. There is no easy peace ahead of them.

One thing above all others stands out. We want our boys and girls to have all the schooling they can use, and to have it now. That is the motive-power behind the Go-to-School drives that are shaping up here and there across the country.

The back cover of this issue of THE CHILD carries a message to boys and girls which agencies and organizations might display on bulletin boards and in centers where youngsters gather.

The Children's Bureau and the U. S. Office of Education would welcome reports from community groups which are staging Go-to-School drives this summer and fall. If you know of any activities, won't you write us about them?

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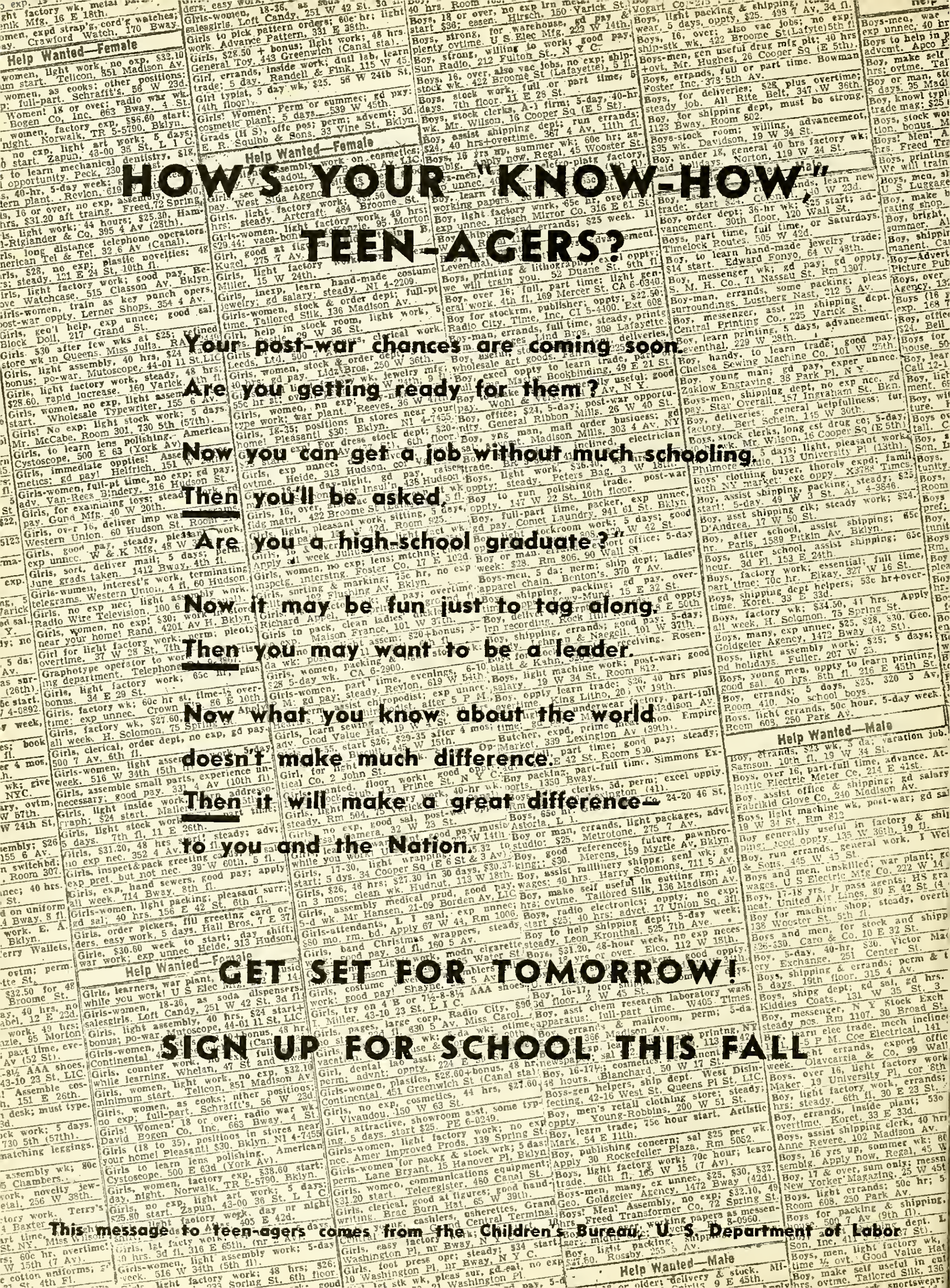

HOW'S YOUR "KNOW-HOW," TEEN-AGERS?

Your post-war chances are coming soon.

Are you getting ready for them?

Now you can get a job without much schooling.

Then you'll be asked,

Are you a high-school graduate?"

Now it may be fun just to tag along.

Then you may want to be a leader.

Now what you know about the world

doesn't make much difference.

Then it will make a great difference—

to you and the Nation.

GET SET FOR TOMORROW!

SIGN UP FOR SCHOOL THIS FALL

This message to teen-agers comes from the Children's Bureau, U. S. Department of Labor

Dup

VOL. 10—NO. 2 AUGUST 1945

The CHILD

CHILDREN'S BUREAU • U. S. DEPARTMENT OF LABOR

Child-Welfare Workers Prepare for I. L. O. Meeting

Emotional Aspects of Convalescence

Accidents Still Take Their Toll of Young Workers

U. S. SUPERINTENDENT OF DOCUMENTS
SEP 14 1945

VOL. 10 · NO. 2 · August 1945

The CHILD

MONTHLY BULLETIN

Editor Miriam Keeler

Assistant Editor Sarah L. Doran

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The photograph on the cover is used by courtesy of the Indiana Department of Public Welfare.

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

NATIONAL BACK-TO-SCHOOL DRIVE UNDER WAY

"A quarter of a million more boys and girls enrolled in high school this fall than last" was announced on August 7 as the goal for this year's Back-to-School Drive, sponsored by the U. S. Office of Education, Federal Security Agency, and the Children's Bureau, U. S. Department of Labor.

The appeal this year is being made in particular to teen-agers who are in summer jobs, those who have been laid off from full-time jobs, and those who are still in school but thinking of dropping out to get a job. These young people are being urged to stick by their No. 1 job of completing their high-school courses, so that they will be prepared for postwar job opportunities and citizenship responsibilities.

Backing the drive, besides the Children's Bureau and the U. S. Office of Education, are the Office of War Mobilization and Reconversion and the Advisory Council of the Retraining and Reemployment Administration. This council includes representatives of Government agencies dealing with manpower problems.

High-school enrollment reached its all-time high in 1940-41, when the number of students enrolled was 7¼ million. For 4 years, war pressures have pushed enrollment down and child labor up. Enrollment dropped 300,000 in 1941-42; 300,000 in 1942-43; 600,000 in 1943-44. Only a negligible drop occurred in 1944-45, thanks largely to the 1944 national Back-to-School campaign. The 1945 drive is expected not merely to maintain present school enrollment but to build it up another quarter million over last year's.

Some of the shrinkage in high-school enrollment has been due to a decrease in the number of boys and girls of high-school age. Most of it has been due to the great increase in youth employment. In the spring of 1945 nearly 3 million were employed. Half of them had dropped out of school entirely. Half were in part-time jobs. (No count is available of the number of youngsters under 14 who are working and not in school.) Some of the 1½ million youths of high-school age who have left school and are in full-time employment may be laid off as cutbacks occur. They are an important pool of potential new students.

Another source of new recruits is the pool of summer workers. In each of the three summers (1943, 1944, 1945) between 4 and 5 million high-school age boys and girls have been at work during vacation. The temptation in the fall to stay in jobs and forego school is enormous. Summer employment undoubtedly contributed to the serious drop in school enrollment in the fall of 1943. The 1944 Back-to-School campaign helped greatly in pulling back to school the boys and girls who had taken jobs. The 1945 campaign is directed again to these summer workers.

Even at the peak of high-school enrollment in 1940-41, some 600,000 students stopped their courses at the end of the ninth, tenth, or eleventh years. Only 60 out of every 100 who entered the ninth grade completed the twelfth year. During the war these drop-outs have greatly increased.

Educators throughout the country are being asked to take the lead in organizing their communities for Back-to-School drives. Last year's experience shows that when all groups in the community take hold, boys and girls can be persuaded that their best interest lies in completing their high-school education. Along with the effort to get the boys and girls into school, educators are being urged to reexamine their programs and courses to strengthen the long-time value of education. Programs that have been geared to wartime conditions must now be readapted to meet the peacetime needs of youth.

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CHILD-WELFARE WORKERS PREPARE FOR I. L. O. MEETING

Exchange news about children's needs at Montreal conference

by KATHARINE F. LENROOT

Chief, U. S. Children's Bureau and representative of the United States at Montreal

Child-welfare experts, one from each of 10 countries and two from Canada, together with representatives of the United Nations Relief and Rehabilitation Administration and of the American International Institute for the Protection of Childhood, met in Montreal, Canada, from May 23 to 30 at the invitation of the International Labor Office to advise the Office in regard to the preparation of material for discussion at the International Labor Conference to be held in Paris this fall. The representative of the United States, who is a member of the International Council of the American International Institute for the Protection of Childhood, also represented the Institute.

Photograph by United Nations Relief and Rehabilitation Administration

REPATRIATING LITTLE CITIZENS like these brave troopers who have lived out the war in Egypt requires much more than a one-way ticket back to homes in war-torn European countries. Wherever possible UNRRA gives them the skilled help of child-welfare workers in making the journey back and the adjustments at home easier.

This meeting was particularly notable because it was the first specialized international gathering in which officials responsible for the health and welfare of children and the protection of young workers in the Western Hemisphere had the opportunity of conferring with representatives of recently liberated countries. Difficulties involved in travel arrangements delayed the arrival of the representatives of France and the Netherlands until very late in the session, but they and the representative of Belgium gave graphic accounts of the plight of children and youth in those countries and the measures already in operation or projected to assure them greater opportunities and fuller protection. The delegate from China drew a picture of the immensity of the tasks of child protection and child care in his country. He is returning to China to assist in a project for training 8,000 social workers, including 1,500 child-welfare workers, for immediate wartime service.

In addition to the material prepared by the International Labor Office and that presented by the delegates, reports and messages were received from the International Bureau of Education, the Conference of Allied Ministers of Education, and the Interim Commission on Food and Agriculture.

The group elected as its chairman Dr. G. F. Davidson, Deputy Minister of National Health and Welfare of Canada, and as vice-chairman Dr. Paula Alegria, Chief of the Office of Women and Minors of the Ministry of Labor and Social Insurance of Mexico. Inasmuch as the chairman was able to be present for only the first 3 days and the last day, much of the discussion was guided by Dr. Alegria.

Six of the members of the group (from Canada, Belgium, France, Mexico, the United Kingdom, and the United States) were connected with national departments of labor; three were or had been connected with Government departments of welfare or of health and welfare (Chile, China, Canada); three (Chile, Peru, United States) were the heads of Government services for children. In addition, a member of the Governing Body of the International Labor Organization, Dr. Rego Monteiro, who was until recently the Director General of the Ministry of Labor of Brazil, attended many of the sessions and contributed greatly to the discussions.

In opening the meeting, the Acting Director of the International

Labor Office, E. J. Phelan, said in part:

> The question of the welfare of children and the protection of young workers was placed on the agenda of the Conference by the Governing Body; that is, by the 16 Governments represented and by representatives of employers and workers. The Governing Body considered it an urgent question; it is not a new one for the International Labor Organization and various aspects of it have been considered since 1919, but the approaches made have been fragmentary—single questions were considered and decisions taken, a method suitable to times of peace. The Governing Body decided that on this occasion the question should be discussed as a whole in its wider aspects, and was led to this decision by the gravity of war problems in all countries; for example, in China, where exists the greatest problem of displaced persons ever known in the history of the world, many of these persons being children and young persons; in Latin America, whose economy has been distorted by war; in the United States and Canada, where important changes in family life have been caused by the departure into the armed forces of millions of men and by extensive employment of women in factories.
>
> These problems must be brought into a general perspective, and for this reason the Office has called together experts from various countries and from official international organizations also interested in this subject. The International Labor Organization has no monopoly of ideas nor of action. The Paris Conference will consider a resolution on general principles. After this comprehensive review, it will be seen which parts should be carried forward by the International Labor Organization and which ones by other organizations. In 1946 the Conference may have to consider those particular points of the resolution which would appear to be appropriate for early action by the International Labor Organization.

It was stressed by the acting director that the meeting was for the purpose of exchange of views without any restrictions and that these views do not commit the Governments of the countries to which the experts belong. Guidance was sought for the preparation of the report to the Conference, which is the responsibility of the Office. In closing, Mr. Phelan stated that the political decisions of the San Francisco Conference and the technical decisions of the Paris Conference would be meaningless unless, in this critical period, the problems of children and young persons are dealt with successfully.

Mme. Marguerite Thibert, Director of the Division of Women and Children of the International Labor Office, amplified the remarks of the acting director regarding the purpose of the meeting. According to the instructions of the Governing Body, Mme. Thibert said, the Office is to prepare a draft resolution to be presented to the next International Labor Conference. The resolution should formulate general principles on child protection in relation to the child's preparation for his future role as a citizen and worker and on the protection of nonadult workers. She referred to the constitution of the International Labor Organization adopted in 1919, which included among the aims of the organization the abolition of child labor and the imposition of such limitations on the labor of young persons as will permit the continuation of their education and assure their proper physical development. She also referred to the Declaration of Philadelphia (1944), which recognizes the solemn obligation of the International Labor Organization to further among the nations of the world programs which will achieve provision for child welfare and maternity protection, and assurance of equality of educational and vocational opportunity.

The importance of coordination of measures was recognized in Mme. Thibert's statement. It was implied in the instructions of the Governing Body that the resolution should lay out a general plan which formulated the principles of social policy for children. Many aspects of these questions are of equal interest to other international organizations; as regards some, other organizations are better equipped to define methods or to undertake practical action. When an outline of principles has been formulated, each international organization could take as its province the carrying out of some particular point of a general program planned for the well-being of children, Mme. Thibert reported that two matters to come before the next International Labor Conference deal with medical examination for the admission of young persons to employment, and with prohibition of night work for young persons in nonindustrial employment.

The International Labor Office has prepared a statement as a basis for discussion. Before this was taken up there was general discussion of the work of the committee, followed by brief reports of conditions in each country represented on the committee and one by the representative of the United Nations Relief and Rehabilitation Administration. It was decided that the points of view expressed in the discussions, as recorded in the minutes, would constitute the record of the meeting and that no special statement by the committee would be prepared nor would formal votes be taken on the points under discussion, since the purpose of the committee was to exchange ideas and inform the Office on the material to be presented to the Paris Conference. Subcommittees, however, drew up material for a preamble dealing with the urgent needs of children and young persons in the countries most affected by the war and with the organization of health and welfare services.

High points in the reports on conditions in countries represented on the committee included the following:

In recently liberated countries: Serious conditions of health and education are reported, rising infant mortality, loss of weight in children, destruction of schools, lack of school equipment, difficulties during the occupation in maintaining effective services for children. The United Nations Relief and Rehabilitation Administration has found that in general in liberated countries the most urgent needs are for food, clothing, medical supplies, fuel, and shelter. As for children, one of the most serious problems is that of homeless and displaced children, of whom a considerable number cannot be identified or are of unknown nationality. Active efforts are being made by the Governments to reestablish, improve, and coordinate services for children. Plans in Belgium include the creation of a General Youth Commissariat, an official body with a triple function, advisory, coordinating, and executive, in regard to the matters not within the jurisdiction of any ministry.

In China: It has been estimated that there are in China 84 million displaced persons, of whom many are homeless children. The Government has set up or subsidized 599 institutions, which care for 200,000 children. Twenty thousand industrial cooperatives care for half a million refugee children. China is predominantly an agricultural country, in which more than 80 percent of the population is engaged in farming. There is strong emphasis on the family, on the importance of the child, and on public responsibility for child welfare.

In the United Kingdom: During the war all social services have continued, though with depleted staffs, and all protective legislation has been enforced, with some modifications. There has been no appreciable increase in the employment of school children. Legislation on hours of employment and prohibition of night work for young persons has been relaxed but kept under control. Emergency orders allowed specified relaxations. Wartime measures relating to the employment of young persons are being carefully revised. There has been great development in communal feeding and improvement in medical and nursing services and in the organization of personnel management. It is proposed to overhaul the social-insurance scheme, and the establishment of children's allowances is being considered.[1]

The new Education Act provides for the gradual raising of the age of admission to industry to 15 and 16 and for continual education for everyone up to 18 years of age. A Government committee is studying the situation of homeless children.

In Canada and the United States: Problems affecting the welfare of children in wartime, some of them involving serious social losses, have led in the United States to plans for expansion of maternal and child-health services, with Federal aid; measures to extend and strengthen social-security systems; strengthening of Federal and State child-labor laws; and recommendations on the establishment of State and local children's commissions or councils to promote a more coordinated approach to the problems of the child. In Canada several plans affecting social policy have been proposed. Definite progress has been made in social security; in family allowances, which went into effect in July of this year; and in the establishment of provincial departments of health and welfare in all provinces not previously having such organizations.

In Latin-American countries: In some countries geographic, racial, and linguistic differences between regions accentuate problems of child health, education, welfare, and employment. Extension of schools is helping to promote a common language. Great progress has been made in education, in the extension of health and social services, in the regulation of child labor, and in the development of governmental services of broad scope for children. Good child-labor legislation is not enough to solve the problems of children, considered not only from the technical, but from the human point of view. As was stressed by the representative of Mexico, only the coordination of services and the unification of social, medical, educational, and labor programs can give the child adequate preparation for the struggles of life.

The "Basis of Discussion" prepared by the International Labor Office included consideration of general social problems concerning children and young persons, including maintenance of children and health and social protection; education; vocational guidance and training; apprenticeship; problems concerning the admission of children to employment, including minimum age, employment and work permits, placement, and social insurance; and problems concerning protection of young workers, including hours of work, night work, wages, safety and hygiene, supervision and control, and other matters. Questions of administration were also included. A subcommittee drew up material on social policy concerning young persons, with special reference to the problems of children and young persons in countries especially affected by the war. A subcommittee on social and health protection drew up a statement for the use of the Office in drafting material on this subject.

In discussing questions of administration, differences in point of view regarding the relative advantages of unified as against coordinated administration of children's services were expressed. All agreed that suitable administrative arrangements would necessarily differ from country to country, depending on political structure, the historical development of various programs, and other factors. There was agreement also on the need for harmonious and comprehensive laws as well as a means for coordinating administration. Adequate administrative systems, with necessary specialization, and a unified social policy of child protection are essential.

The International Labor Office, after reviewing the minutes of the meetings of the committee, is preparing a draft resolution and a report for the next International Labor Conference. The title "Youth Charter," originally proposed for the resolution, was dropped in favor of a somewhat more restrictive title, which would indicate that the scope of the proposed Conference resolution was for the most part to be confined to employment matters.

In closing the meeting, Mr. Jef Rens of the staff of the Office said:

> A meeting like this one is among the most interesting of those held by the International Labor Organization. There are no high-sounding phrases and empty words, but a sincere and valuable exchange of views which gives fruitful results. We are especially grateful to the experts from the liberated countries who have made us understand the living conditions of children in their native lands.
>
> The wide experience that experts from Asia, Europe, and both North and South America have brought to the meeting will be of the greatest value to the Office in the preparation of the resolution, and it is hoped that the result will be a document acceptable to nations in every part of the world.

●

On June 30, 1945, the Governor of Illinois signed a new child-labor law, which will become effective 6 months after the end of the war. Among its more important advances the act includes a 16-year minimum age for work during school hours in manufacturing establishments, canneries, laundries, restaurants, and several other types of establishments, as well as a limitation of 3 hours a day on school days for work of minors under 16 years of age employed outside school hours.

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[1] An act establishing children's allowances was passed in June. See p. 22.

NEW FAMILY ALLOWANCE ACTS COMPARED

Prior to its adjournment in June 1945 the British Parliament passed a Family Allowances Act, providing for monthly payment by the Government to British families on behalf of each child in the family except the first. This act is one of the measures proposed in the Beveridge report in the hope of establishing a comprehensive social-security program in England, and its passage may be regarded as a first step in the implementation of the Beveridge report. (Also of direct benefit to children is the passage of the Education Act, remodeling the structure of the school system and making provision "for family allowances to be supplemented through supplying free milk and meals to school children on a scale that will ultimately cost £60,000,000 a year.") *London Times, June* 16, 1945.

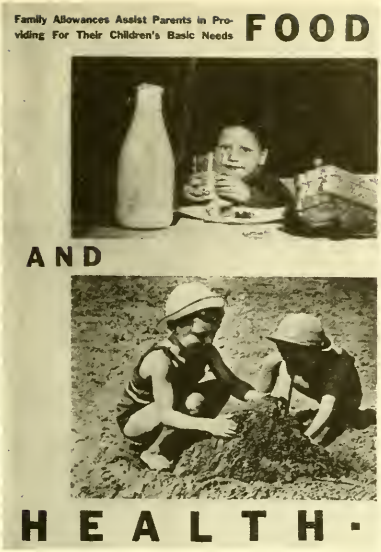
The British Family Allowances Act is similar to the Family Allowances Act of Canada, which was passed in August 1944 and became effective July 1, 1945. These acts are an attempt on the part of the Governments to lighten the burden of child support, especially those in large families. Both the British and the Canadian plans provide for regular payments from general Government revenues to families with children. The intention of the Canadian act is stated as follows: "The allowance shall be applied by the person receiving the same exclusively towards the maintenance, care, training, education, and advancement of the child." The British act describes the purpose of the allowance to be "for the benefit of the family as a whole." Actually this difference in emphasis is likely to be of little significance in the use of the funds.

Both England and Canada have incorporated the administration of the family-allowance acts into newly organized Government departments. The British program will be administered by the Ministry of National Insurance; and Canada's program is placed in the Department of National Health and Welfare, where it is administered in the Welfare Division.

GREAT BRITAIN	CANADA
ELIGIBILITY	
All children, except the oldest in the family, eligible until they reach upper age limit for compulsory schooling (15 years), or until the August after their sixteenth birthday if they are still in school or receiving apprentice training.	All children under 16, except that children over 6 and under 16 are eligible only if attending school.
POLICY REGARDING DUPLICATION	
1. Children for whom orphans' pensions are paid do not receive family allowances; nor do children receiving equivalent benefits in connection with the parent's military service or war injury.	1. In order to prevent duplication, family allowances may be reduced or withheld in consideration of other benefits paid to the family by the Canadian Government. No such reduction or withholding, however, may be made in the case of children of servicemen who are receiving benefits in connection with the parent's military service.
2. Reduced family allowance is granted if person is receiving funds under outdoor relief, unemployment assistance, or old-age or widows' pensions.	2. Bonus for dependents under unemployment-insurance plan not affected by family allowances. Family may receive benefits for child under both laws.
3. Income-tax deduction for children continued; family allowance is taxable income.	3. Allowance not subject to taxation under income-tax law, but income-tax deduction for child is decreased by the amount of the family allowance received. Family has option of applying for allowance or for tax deduction, whichever would benefit it most.
PAYMENTS	
Five shillings a week for each eligible child. (Approximately $1 a week in United States currency at present rate of exchange. This does not, however, take into account the greater purchasing value of money in England.)	Payments vary according to age of child and number of children in family as follows: *Age of child* — *Monthly allowance* Under 6 years.... $5 6-9 years......... 6 10-12 years....... 7 13-15 years....... 8 Reduction of $1 per month for fifth child in family, of $2 for sixth and $2 for seventh, and of $3 for eighth and each additional child.
Statute says that allowances belong to wife, but are receivable by either man or wife if they are living together	Payment may legally be made to either parent. Determination of recipient left to Provinces, and, according to reports, all payments are made to mother.

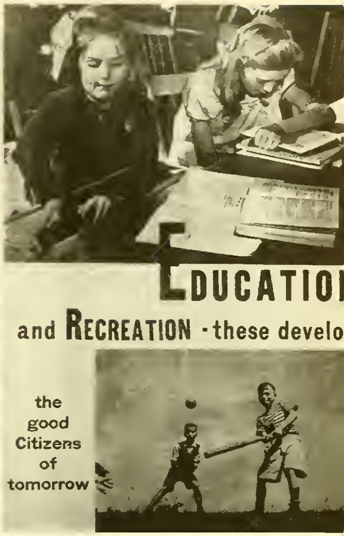
FAMILY
LLOWANCES
The Children's Charter

Family Allowances help to assure for each child the basic necessities of life, physical and social development. Under the Family Allowances Act parents of children under 16 are entitled to monthly cash allowances.

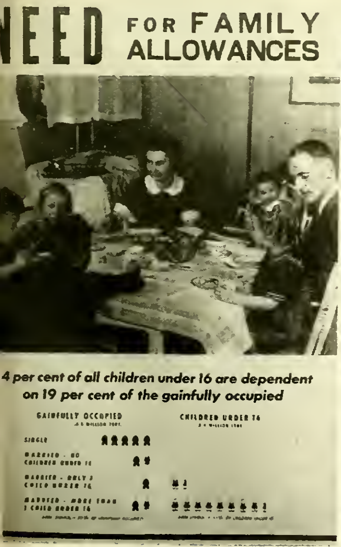


Family Allowances Assist Parents in Providing For Their Children's Basic Needs

FOOD
AND
HEALTH


DUCATIO
and RECREATION - these develo
the
good
Citizens
of
tomorrow

THIS SET OF SIX POSTERS shows how the Canadian Government informs families about the Family Allowances Act. Copies of the posters may be had without charge by writing to the Canadian Wartime Information Board, 1205 Fifteenth Street NW., Washington 5, D. C.



EED FOR FAMILY ALLOWANCES

4 per cent of all children under 16 are dependent on 19 per cent of the gainfully occupied

CHILDREN are entitled to...

UNDER SIX $5 PER MONTH

UNDER TEN $6 PER MONTH

UNDER THIRTEEN $7 PER MONTH

UNDER SIXTEEN $8 PER MONTH

Children bear the promise of a better world. Canada's children are its greatest asset. Family Allowances help secure for each child greater opportunities for a good start in life.

EMOTIONAL ASPECTS OF CONVALESCENCE

Fulfillment of child's emotional needs is factor in physical as well as psychological recovery

by MILTON J. E. SENN, M. D.

Associate Professor of Pediatrics in Psychiatry, Associate Attending Pediatrician, New York Hospital and Cornell University Medical School, New York City

In the history of a sick person it is not easy to say when convalescence begins nor when it ends. It is equally difficult to differentiate between the physical signs and symptoms which belong to an illness and those which are part of its reparative process. Similarly, an appraisal of the emotional aspects of convalescence introduces perplexities. Despite the difficulties in delineating the boundaries of convalescence and in enunciating the characteristics of that period, an attempt will be made in this paper to describe the reactions of infants and children who are recovering from physical illnesses, to discuss the forces and motives underlying the emotional responses, and finally to mention some of the psychotherapeutic aids which are useful in treating sick children and in promoting recuperation.

Child a living, changing person

In a consideration of illness and of returning good health it is important that the child be considered as a living, changing person whose mind and body jointly share in the progress of recovery and in the process of growth. An interplay of the forces of physiology and pathology, influenced by endogenous psychological factors and by various exogenous phenomena produce the emotional reactions, and since all these powers are dynamic the resultant feeling tones are moving and changing.

Dominant emotion in illness important

While in general it may be said that a child in illness and convalescence is experiencing the same emotions as in health, and on occasion may be happy, worried, optimistic, depressed, fearful, anxious, hopeful, resentful, and so on, it must be pointed out that his dominant prevailing affective state is of greatest concern. In illness and convalescence this may be quite different from that demonstrated in health. The difference may be due to a specificity of the disease process. This occurs most frequently in persons who have pathology of the central nervous system and may be illustrated in patients with general paresis, whose predominant emotional state is that of euphoria, or instances of brain trauma and encephalitis with fearlessness in defiance of authority as the dominant characteristic mood. But in these patients with disease of the central nervous system, as in all other sick persons, there is a nonspecific emotional response as well.

At one time it was thought that the area of the body which housed the pathological organ determined the mood of the patient; for instance all diseases of the thorax were supposed to produce euphoria, while those of the abdomen resulted in melancholia. It was also held that certain illnesses always brought forth explicit mental states, as for example pulmonary tuberculosis, which was supposed to produce a more or less continuous feeling of exaggerated optimism and hopefulness. It is now recognized that the disease processes are not the preordaining influences, but that various psychological factors predicate the emotional response of each person when he is ill and as he gets well.

The emotional response of a sick child to his illness and convalescence

THE PHYSICIAN who consciously tries to avoid producing physical fear, who is attentive to the timing of his therapy in terms of the psychological as well as the physical needs of the patient, who does not deceive his patients, and who takes the time to listen to their doubts and fears and to answer their questions exerts powerful influences of reassurance which prevent psychological complications of illness.

Photograph by Philip Bonn, Children's Bureau is dependent on various important factors. These may be enumerated as follows:

1. The physical, intellectual, and psychological status of the individual at the onset of his illness. This is largely determined by what went on before in his growth and development, beginning with conception, and in life experiences from birth onward, especially in terms of relationships with parents and siblings in the specific cultural milieu in which he was reared.

Prenatal influences

It is very important to remember that one does not begin as a human being at his birth. We are increasingly cognizant of the fact that prenatal influences, psychologically and physiologically, have a great importance. We also must remember that the health of the mother, emotionally, with her interest in her coming child, is of tremendous importance, because there may begin to be during pregnancy a very close emotional bond between mother and child. That is the place for it to begin, and it is the place for the pediatrician to begin to think in terms of the child not only as a physical being, but as one who has personality and who is closely tied emotionally to his mother.

2. The nature of the illness. The acuteness, type, severity, and duration of symptoms, the length of convalescence, and the amount and kind of physical residua are important items. The character of the medical and surgical management is included in this category.
3. The meaning of the illness to the patient. This includes consideration of the attitudes of the sick child during the period of ill health and of his preexisting feelings about body, health, disease, and life in general.
4. The interpersonal relationship of patient and nurse, and of patient and physician. This includes attention to the personalities of the medical and nursing staffs caring for the child as much as to the personal characteristics of the sick person.

Factors overlap

Although there is overlapping of these factors, discussion will be centered about each item with emphasis on its relatedness to the others.

Assuming that the patient has normal intelligence and has been able to use optimally the opportunities for growth and development in the area of reasoning, learning, and remembering, the state of his physical and psychological being at the beginning of his illness constitutes the first important determinant as to how he will react to the changes in his body. Such things as the degree of dependency on his mother and the methods of parental management in meeting the attempts at self-assertion and self-expression in the child's strivings for independence and in training him to new habits will influence his emotional reaction to the illness which interrupts his growth. The infant who is physically dependent on his mother for food feels close to her psychologically as well. If the nature of the disease is such as to demand new and different eating habits the baby experiences fear of separation from his mother as well as fear of new methods of feeding, and this may produce a train of gastrointestinal symptoms which in turn cause feelings of discomfort and pain and emotional states of hostility, anger, irritability, and frustration.

A psychological lag

Convalescence may begin physically through excellent medical and surgical care but often is delayed and prolonged while there is a lag psychologically because the infant cannot accept with satisfaction the substitute feeding regime which may be ideally suited to him from the standpoint of nutrition and physiology. The pediatrician frequently sees such a baby, who won't eat well or gain weight while in the hospital, turn about and eat heartily and joyfully when fed by his mother in the home.

Two-year-old both dependent and independent

The child of 2 years who has reached a point in his development where he feels ambivalent toward his mother, wanting to be independent of her yet at the same time feeling very dependent, often shows his dilemma by an aggressiveness of action, as if he were trying out his powers of independence. He expresses this aggressive attitude with some misgivings, however, feeling threatened by the loss of his loved parent, even though the latter may never have menaced him with such a punishment. When illness comes to such a child, he is apt to relate it to his sentiments, and if treatment demands removal from the parent he is overwhelmed with emotions of guilt and of fear of permanent separation from his loved ones. Here again, physical convalescence may be slow and irregular while the child shows mixed attitudes and behavior, often characterized by acts of aggression, hostility, or defiance or by withdrawal into submissiveness and undue placidity, all with a strange undertone of anxiety, fear, and resentment. Even after return to home and parents, such children may carry over feelings of fear, as if expecting a recurrence of separation.

Some children predisposed to emotional change

The emotional responses of children to mild upper-respiratory infection have been described by Richter.[1] Twelve children ranging in age from 5 to 14 years, most of them adolescent, developed syndromes of anxiety, depression, and compulsive-obsessivephobic thinking and acting within 1 month after the onset of mild symptoms of "cold" or "grippe." The psychological phenomena lasted from 6 to 9 months after the physical illness was over. Specific etiological factors were not determined, but it is interesting that each child had similar personality characteristics before his illness, as if to denote that there was a personality predisposition to the emotional changes. All the children who developed the disease had been docile, subservient, cowed by authority, perfectionistic in their strivings, and meticulous in personal habits; as a group they were repressed and nonaggressive and possessed qualities which were valued in society. It seemed that in health these children had difficulty in expressing their hostile feelings, but with illness the barriers were lowered and the individuals responded with aggressive thoughts and acts, although during the sickness each child interpreted illness as "punishment" for some supposed naughtiness or wickedness.

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[1] Richter, Helen G., M. D.: Emotional Disturbances of Constant Pattern Following Nonspecific Respiratory Infections. Journal of Pediatrics, Vol. 23, No. 3 (September 1943), p. 315.

This group of case histories is interesting because the emotional display shown here is seen frequently in adolescents, who normally have strong feelings of right and wrong, who are fearful of body change and misinterpret even slight deviations of development as significant of great pathology, related somehow to acts of omission or commission. The case summaries of Richter are important too in pointing out the duration and lag of psychological convalescence in comparison to the physical recuperation.

Sudden illness may cause emotional shock

In considering the second important determinant of a child's emotional response to physical illness and convalescence, attention is focused on the nature of the illness. One which strikes with suddenness, demanding immediate change of setting without benefit of psychological preparation, such as in a disease warranting immediate hospitalization and operation, stimulates feelings of uncertainty, confusion, fear, and anxiety; these result frequently in emotional shock, which persists for a long time in the period of recovery. Symptoms of such a condition, which has also been called "fright neurosis," are those of general irritability, sleeplessness, night terrors, and attacks of anxiety, with vasomotor and secretory disturbances. These symptoms are well recognized by surgeons, who attribute delays in postoperative recovery to their severity. Finney[2] has pointed out the importance of adequate psychological preparation in reducing the incidence of these emotional reactions. A detailed description of the process of assimilating anxiety which prepares a person to withstand a surgical operation is given by Deutsch[3] in a paper on psychoanalytic observations in surgery.

In his autobiography, Finney talks about a man that needed an operation. He was examined and was sent to the Johns Hopkins Hospital, and when it came time to operate he was found to be very disturbed, with a mood of restlessness and hypertension, and the operation was postponed. It was postponed for several days, but this restlessness did not disappear. He came back again and was again found to have hypertension and to be distraught, restless, and fearful. He was sent home. He returned the third time. This time, when Dr. Finney saw him, he did not have hypertension; he seemed quite at ease, and Finney thought it was strange, and by accident he talked to the porter.

The porter said, "You know, it is a funny thing with that man in the room; when he came into his room he began to be very upset, and as I walked in I said, 'Gee, you are a lucky fellow.' He said, 'What do you mean?' I said, 'You have got Finney for your doctor,' and he said, 'Why is that lucky?' And I said, 'You know, Finney seldom loses a case.'" After that the man did not seem so restless, and Finney thought that this porter's reassurance had been the specific psychotherapeutic aid that put the man at ease.

Location of illness significant

In the discussion of how the nature of the illness affects the emotional response, mention must be made of the fact that the location in the body of the pathological changes and their permanency in making the child different from his peers are very significant. An infant or young child will not feel embarrassed by disfigurement of face or deformity of extremity even though his parents will have strong emotional reactions of guilt and unhappiness and may transmit to him some of their feelings. However, as the child grows older his handicap may bring forth a spectrum of emotional display, especially of self-pity, anger, resentment, and unhappiness. His response may be furthered by physical protest or by emotional repression, and if it is primarily the latter there will follow by virtue of conversion mechanisms a new train of physical-psychological symptoms, especially headache, dizziness, abdominal discomfort, and gastrointestinal manifestations, which dominate and prolong convalescence and interfere with therapy until psychiatric assistance is provided the patient and is accepted by him and his parents. Another group of children who react similarly because of the nature of their illness are those with cerebral palsy, who demonstrate great fear of falling and of being dropped, and who improve physically and mentally only when able to become relaxed and trusting in the hands of persons who, they feel, love them.

What illness means to the child

Then there is the third item in our outline; namely, the meaning of the illness to the child. So far, stress has been placed on the fact that illness may be a threat to a child. It may suggest a fear of separation from loved parents or from life itself. It may threaten his security, his life's ambitions and dreams, or his way of looking at himself admiringly.

If his response to threatening life situations has customarily been one of defiance, he will probably react to illness and convalescence with contempt, and he will be disposed to resist the attempts of others to help him get well. He opposes the assistance of medical and nursing staffs and of social workers, preferring "to see things through" by his own design, as if the whole episode were a test of his capabilities as a person. Convalescence for such a child may be irregular, with fluctuations back and forth as he prematurely attempts to take up normal activity. The child with heart disease, for example, when he begins to feel better often resists restraint and tests out his own notions as to management. It is important then that the recommendations by the medical and nursing staffs should be based on sound physiological and and psychological reasoning, lest the child's experiments disprove their validity and increase his skepticism and resistance.

One is reminded of the advice given occasionally to such a child that if he were to perform a certain act, so-and-so would follow. Challenged and feeling defiant, he carries out the forbidden activity, and when no apparent harm follows and the predicted results do not appear the child loses trust in his medical adviser and formulates further his own ideas of medical management. One example of an unphysiological response to theoretically sound advice is furnished by a child known to us who has bleeding tendencies and who was told that he must move around little lest he start bleeding. This boy's reaction was one of fear to the point of developing external involuntary motor restlessness, which increased his anxiety still more because it provoked further demands of complete rest from his physicians. A further response in this patient was fear of bleeding to death at night, so that he slept fitfully. He was reassured only when told that nurses would look at him often during the night. Feeling ashamed at being different from his fellow patients, this 10-year-old boy also rationalized his state by claiming to have originated during infancy power to bleed at will. As one got to know him in the hospital, his true feeling was acknowledged; namely, that he considered his present illness as punishment for something "bad" he had done earlier in life.

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[2] Finney, John Miller Turpin, M.D.: A Surgeon's Life; the autobiography of J. M. T. Finney. G. P. Putnam's Sons, New York, 1940. 396 pp.

[3] Deutsch, Helene, M.D.: Some Psychoanalytic Observations in Surgery. Psychosomatic Medicine, Vol. 4, pp. 105-115 (January 1942).

What can we do for this child as a child?

We all know the child who develops marked restlessness when complete bed rest is suggested. In two children's hospitals in this country I saw a boy and girl, interesting examples of this. First, a girl of 10 was admitted in the springtime because of Sydenham's chorea. She was admitted one week after the onset of her illness, which came suddenly when her father deserted the family. In the hospital the child was very active. She was given phenobarbital in increasingly larger doses, and it did not do any good. The next fall at a staff meeting an intern, who had come on in July and inherited this child who had been admitted in the springtime, brought up for discussion the question of how to care for this child further, because that morning she was found sitting on a window ledge threatening to jump out and commit suicide because she objected to staying in the hospital and because of the fact that her mother was allowed to visit but once a month, and the question that arose at the staff conference was: How can we sedate this child further?

Why was this child objecting to the hospital stay? What more could we do for this child as a child? When it was suggested that the problem was not one of sedation, but rather one of looking at the child and seeing that her needs were fulfilled, we soon developed a child who was very quiet and very happy and who was discharged very soon.

Sedatives failed

The second case was a boy of 8. When I was making the rounds with the staff one day, the question of what to do with him came up, because he was a boy of great motor restlessness, especially in the early evening. This boy, too, had been admitted because of chorea, which had never subsided even though increasing amounts of sedative had been given. In the evening, when the children were supposed to go to sleep, this boy became still more overactive and restless, and the problem was: Shall we change from phenobarbital to bromo drugs, or what drugs shall we substitute? There was some discussion about that, and an intern stood up and said, "I have something to admit. I am very worried about something. This boy is my patient. He has been a great problem to me. He has been annoying to me, and last night, when he was supposed to go to sleep, I hauled off and hit him in the face. I am very sorry for this. I would like to make up to him now, I would like to do something. I have not done right by him. This boy has two requests that he keeps making. One is that he be allowed to wear a brown suit." (The boy, being at rest, was not dressed. He had not been given a hospital jumper, which was a brown suit, like the other patients.) "The other request," went on the intern, "was to be allowed to be up on the roof during the day. We have not given him that privilege because we are afraid that he cannot stand it, because his heart won't take it. I would like to try stopping the phenobarbital and give him a bromo and have him go up on the roof and see what will happen." That was done, and after a few days this boy was absolutely quiet and was discharged and has had no recurrence of chorea or of cardiac or other rheumatic manifestations.

In contrast to children who respond to illness with resistance, there are others who reply with feelings of pleasure. It is quite likely that in all of us pleasure is mixed with pain, and that illness may foster emotions of relief and joy after initial feelings of pain and displeasure, and that convalescence may offer surcease from a life of struggle and turmoil. This is expressed in modern psychiatry as "the secondary gain" of illness. The sick person finds that his reliance on others for special care and for protection is enjoyable, much as it was in early childhood and infancy, and he may consciously and unconsciously prefer to prolong this state of dependency rather than return to good health and the obligations of normal living. Children with such feelings often regress too in their habits of eating, toilet training, and sleeping. Only when health holds greater compensation than illness will they give up invalidism and special privileges, and even then they will continue to reflect on the illusory advantages of being sick.

Child's response depends on adults

This paper has so far been concerned with the personality reactions of sick and convalescent children, but it must be emphasized that their emotional responsiveness is dependent in some degree on the personal characteristics of the adults who take care of them. The conscious, and especially the unconscious, tendencies of parents, physicians, nurses, and other workers in close contact with infants and children leave marks upon their psychological performance and development. Any restlessness, fussiness, apprehension, irritability, as well as optimism and joy, will be communicated to them. Previously mention was made of the fact that sick children often regress in their habits to an infantile level. In this state of dependency they look for mothering from medical and nursing staffs as from parents, and if a happy transference relationship is set up between the ailing child and an adult who acts as a parent-substitute, a reestablishment of health may follow rapidly. On the other hand, a prolongation of convalescence may ensue if the child fears that once he is better he will lose this new, loving parent or if the nurse does not realize that a strong emotional tie has been set up, which must gradually be deflected back towards the real parents. A nurse, as a professional person, like the mother should know herself thoroughly so that she may watch her reactions and understand the role she is playing, lest unwittingly she foster undue dependency through the exercise of what on the surface appears to be very good nursing care.

Relation between patient and physician

The interpersonal relationships of patient and physician also evoke feelings in the ailing child. The role of the physician is variable, and he too becomes a parent-substitute, a person of authoritative function, a hero, and even an individual with magical power. As a member of a committee on admissions to a medical school, I am impressed by the number of candidates who date their interest in medicine as a career to the time when certain physicians took care of them. On the other hand, one sees children under therapy in a psychiatric clinic who date their neurotic illnesses to frightening episodes in physicians' offices and in hospitals. Psychological evidence shows that painful memories linger in the background of the mind and reappear from time to time as fear of many things. The physician who consciously tries to avoid producing physical fear, who is attentive to the timing of his therapy in terms of the psychological as well as the physical needs of the patient, who does not deceive his patients, and who takes the time to listen to their doubts and fears and to answer their questions exerts powerful influences of reassurance which eventually lessen the period of convalescence and prevent psychological complications of illness.

One is naturally led at this point to mention other psychotherapeutic aids which are useful in promoting good health and recovery from sickness. There should at some point be mentioned the values of different dwelling places for a convalescent child. For some, especially the infant and young child, the home will stand out as the most ideal if the necessary physical treatment can be carried out unhampered. If hospitalization or placement in a convalescent home is indicated, that place should resemble the normal home life as much as possible. Home is extremely personal; the hospital atmosphere should simulate the home in this regard.

Infants and children should be permitted to keep the ties with parents and home through regular visits, and the older children in addition should be permitted to keep up indirect communication through mail and telephone messages. On admission to a hospital, social-history data should be obtained from parents as to family relationships, individual toilet habits, toilet idiosyncrasies, eating methods, food dislikes, and so on in order that all who plan for the child in his new residence may more easily make it resemble his permanent living conditions.

Trained social-service workers are able to help family and child bridge the gap between home and hospital through interviews before admission, and especially at the time of admission. These workers, through continuous contact with the child in the period of hospitalization, may help him to maintain a sense of belonging to his family even though he is away. Like anyone else in the group who cares for the patient they may be chosen by him to function as depositories for the inner feelings which arise in the child at each change in hospital routine.

Adolescent welcomes freedom

The adolescent often welcomes the opportunity to leave his family and benefits by separation because it represents the emancipation which he is striving to accomplish. If those who attend him have reached a maturation of personality development so that they are able to treat him as an individual in his own right, he will attempt to emulate their manner of living as adults without the feelings of ambivalence which usually surround relationships of adolescent and parent.

With each patient, attempts should be made to foster a feeling of stability. Frequent uprootings of residence in even such minor changes as shifts of bedrooms add to potential feelings of apprehension and prevent bonds of friendly attachment from developing which are so essential for promoting security.

It is understood that knowledge of the healthy infant and child must be had before one can deal adequately with the sick and convalescent. Without this information one does not know what goals are to be sought in the restorative processes, nor what reactions of thinking and acting are to be expected from each individual. Much of this information will come from parents, or from the children as they play.

Play

In children, play is a natural medium for communication. It permits a child to tell us things about himself as a person, his physical abilities, and his feelings. It enables him to try out physical energy, to experiment with newly discovered endowments, and at the same time to gain something psychotherapeutically as he relates his experiences and emotions to others. It brings relaxation and rest, diverts the mind from stress, and acts as a safeguard against the development of undesirable habits such as excessive thumb-sucking, masturbation, and day-dreaming, through providing opportunity to express tension, anger, and resentment. Opportunities for diversional and occupational play should be provided each child in keeping with his physical, intellectual, and emotional needs. Bedside and group instruction for school-age children also should be available so that the child may develop a satisfaction of achievement comparable to that experienced by his peers who are in full activity and whom he may join on a level of equality in accomplishment when he returns to school.

In this paper, attempts have been made to present the emotional aspects of convalescence as moving forces, related to the changing physical states of a child growing in a constellation of other individuals. Convalescent care was described in terms of dynamic mechanisms with the aim of restoring physical function and mental well-being and of preventing as much as possible all psychological and somatic residua.

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ACCIDENTS STILL TAKE TOLL OF YOUNG WORKERS

Nine States report startling wartime increases in injuries

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One of the striking features of the war period is the great increase in industrial injuries to minors under 18 years of age. In part this reflects the tremendous rise in youth employment, both legal and illegal, that has occurred, with the accompanying increase in exposure of boys and girls to accident and health hazards on the job.[1] In a large part, however, it is due to the fact that, whether or not they are legally employed, young workers tend to have a higher accident-frequency rate than adults in comparable occupations. This is because they are usually inexperienced and also because they are just young—more adventurous, less mature in judgment, and less responsible than older persons.

Because no Nation-wide estimates of the number of industrial injuries to minors under 18 years of age are available, it is necessary to search for these data in the statistical reports issued by State workmen's compensation commissions and departments of labor. Only a minority of the States tabulate information showing injuries to workers in this age group. In this minority, however, are a number of the larger industrial States. The figures published in these reports are usually based on industrial-accident and occupational-disease cases reported by employers and insurance companies to the appropriate State agency for the purpose of complying with the State workmen's compensation law. In no State do the statistics include all injuries occurring on the job. At best they include only those injuries that come within the scope and coverage of the State workmen's compensation law. No two State compensation laws are alike. This means that the statistics on industrial injuries are not comparable between any two States, even when similar terms are used.

What State Statistics Show

Recent statistical information available for nine States—Illinois, Maryland, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, and Wisconsin—show a remarkable upward trend in injuries to workers under 18 years of age. (All nine States include minors illegally employed within the coverage of their workmen's compensation laws. All but two of these States—North Carolina and Ohio—provide additional compensation for minors injured while illegally employed.) In one of these States the rate of increase between 1940 and 1943 was 1,100 percent; in another, more than 1,300 percent. But let each State tell its own story.

Illinois.—The number of compensable industrial injuries to minors under 18 years of age reported to the Illinois Industrial Commission rose from 282 in 1940 to 1,867 in 1943, an increase of 562 percent.

For the group under 16 years of age the number of reported injuries was over five times as great in 1943 as in 1940—141 as compared with 26. Even children under 14 years shared in the increase, for only 2 of this age group were reported injured in 1940, compared with 31 in 1943.

Injuries to 16- and 17-year-old boys and girls rose from 256 in 1940 to 1,726 in 1943, an increase of 574 percent.

Maryland.—Workmen's compensation claims filed by minors under 18 years of age with the Maryland State Industrial Accident Commission numbered nearly four times as many in 1944 as in 1940, rising from 200 in 1940 to 772 in 1944.[2] Children under 16 years of age, most of them either 14 or 15 years old, filed 10 times as many claims in 1944 as in 1940—73 as against 7. The 16- and 17-year-old workers filed 699 claims in 1944 compared with 193 in 1940, an increase of 262 percent.

Michigan.—According to the most recent quarterly statistics published by the Michigan State Department of Labor and Industry, the number of compensable cases reported for minors under 18 years of age rose from 330 in 1942 to 1,027 in 1943, an increase of 211 percent in a single year. The total for the first 9 months of 1944 alone, during which 849 cases of injuries to minors were reported, represented an increase of 157 percent over the entire year 1942.

New Jersey. — Industrial-injury statistics for New Jersey represent the number of compensated cases closed in any given year. For all minors under 18 years of age the number of cases closed nearly trebled between 1940 and 1943, rising from 308 to 893. Most of this increase occurred among the 16- and 17-year-old workers. In this age group the number of cases closed rose from 283 in 1940 to 827 in 1943, an increase of 192 percent.

For children under 16 years of age the number of cases closed in 1940 was 25; in 1943 it was 66. Most of these youngsters were either 14 or 15 years old, although a few (2 in 1940 and 6 in 1943) were under 14 years of age.

New York.—The year 1942 is the latest for which State-wide data on the total number of injuries to minors under 18 years in New York have been published. Some indication of later trends, however, at least as far as accidents to illegally employed minors are concerned, is given in the following statement made by the State department of labor:

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[1] Census estimates indicate that the number of minors 14 through 17 years of age at work increased from less than 1 million in March 1940 to nearly 3 million in April 1945. During the 1944 summer vacation period about 5 million were employed.

[2] The 1940 figures represent the year from November 1, 1939, to October 31, 1940; the 1944 figures represent the calendar year 1944.

> Along with the greater use of youngsters in the labor force and the sharp increase in the number of child-labor violations there has been a startling rise in the accident rates of children. In New York State the number of accidents to minors employed illegally has increased sevenfold since 1940. The State workmen's compensation law provides that where minors under 18 are employed in violation of the labor law compensation for accidents to them is double the amount otherwise payable. Such double-indemnity cases in New York State increased from 48 in 1940 to 346 in 1943.[3]

In the New York City compensation district alone, awards of double indemnity for accidents to minors injured while illegally employed numbered 33 in 1941, 95 in 1942, 289 in 1943, and 548 in 1944. These tremendous increases are ascribed by the New York State Department of Labor to the wartime increase in illegal employment of minors.

North Carolina.—Unpublished figures on injuries to minors in North Carolina under 18 years of age have been made available to the Children's Bureau for the year ended June 30, 1943, and the year ended June 30, 1944. They represent the number of compensable cases reported to the North Carolina Industrial Commission during each of these 2 years.

In the year ended June 30, 1943, the total number of compensable injuries to minors under 18 years of age was 341. In the following year it was 547, an increase of 60 percent in 1 year alone.

For the group under 16 years the number of compensable injuries rose from 28 in the earlier year to 52 in the later year. Most of this increase took place among children 14 and 15 years old. Nevertheless 5 of the 28 injuries reported during the earlier period and 12 of the 52 reported during the later period involved minors under 14 years of age. The age ranged down to 10 years in 1943 and to 11 in 1944.

Ohio.—The most recently published statistics on industrial injuries to Ohio minors under 18 years of age are based on the number of claims filed with the Ohio Industrial Commission. The figures include injury cases in which no time was lost in addition to cases involving loss of time, other types of disability, or death.

In 1940 the number of industrial-injury claims filed by minors under 18 years of age was 1,177. In 1943 this figure rose to the astounding level of 14,127, a number 12 times as great, representing an increase of 1,100 percent.

The greatest proportionate increase occurred among minors 16 years old. Their claims rose 1,670 percent—from 306 in 1940 to 5,417 in 1943. The next largest proportionate increase—971 percent—was among the 17-year-old workers, the number of whose claims rose from 713 in 1940 to 7,639 in 1943.

Children under 16 years also showed a heavy increase in number of claims. In 1940 they filed 158 claims, and in 1943 the number rose to 1,071. This was an increase of 578 percent.

Among the children under 16 years of age who filed claims in 1943 were 117 who were not yet 14 years old. Of these 117 children, 60 were 13 years old and 57 were still younger. In 1940, claims were filed for 10 children 13 years old and 6 under 13.

Since accidents involving medical expense only, with no loss of time, greatly outnumber those causing death or some type of disability, the Ohio figures are much larger than they would be if they excluded, as a number of States do, those injuries that are not compensable under the State compensation law. Ohio has, however, recently compiled unpublished data showing the number of "lost-time" and other disabling injuries for minors under 18 years of age, based on claims filed during 1944. These total 4,007 for all workers under 18 years of age, 447 for children under 16 years, and 3,560 for workers 16 and 17 years old. Forty-seven children were under 14 years of age, of whom 17 were under 13 years and 30 were 13 years old. No comparable data are available on this basis for other years.

Pennsylvania.—Like Ohio, Pennsylvania shows a startlingly high increase between 1940 and 1943 in industrial injuries to young workers. Injuries reported for minors under 18 years of age numbered 354 in 1940. In 1943 they totaled 5,115. This represents a rise of 1,345 percent. Injuries to workers 16 and 17 years old accounted for most of the increase, for in this age group the number of injuries rose from 317 in 1940 to 4,764 in 1943, or 1,403 percent.

Injuries reported in 1943 for children under 16 years—most of them either 14 or 15 years old—were nearly 10 times as many as in 1940—351 as against 37. For the age group under 14 years the number of injuries reported in 1943 was 17, compared to 3 in 1940.

Wisconsin. — Industrial - injury statistics in Wisconsin are based on compensable cases of injury settled during a given period. In 1940 the number of cases settled involving minors under 18 years of age was 124. In 1944 it was 1,297—10 times as many as in 1940.

The number of compensable cases settled for minors under 18 years of age who were illegally employed rose from 37 in 1940 to 257 in 1944. Although this obviously reflects a large increase in the number of children illegally employed in Wisconsin, it does not necessarily mean that the proportion of illegally employed minors has increased. In fact, the proportion of injury cases of illegally employed minors to the total number of injuries to workers under 18 years of age declined from 30 percent of the total in 1940 to 20 percent in 1944.

Putting Facts and Figures to Work

Statistics and stories picturing the accident and health hazards to which young workers are exposed, are much needed in all States. It is not enough to learn how many accidents occur, but also how, where, and why they happen. What industries, what jobs, what specific kinds of activity on the job appear to cause injuries to young workers? How severe are these injuries? Are the working conditions of these boys and girls in line with State and Federal child-labor laws, with safety and health laws, and with good practice? Do these young people need more training, better supervision?

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[3] Child Labor in Minimum Wage Industries, Summer 1943. Bureau of Research, Division of Women in Industry and Minimum Wage, New York State Department of Labor. Albany, 1944. 10 pp. Processed.

Accurate statistics on industrial injuries, collected, tabulated, and analyzed periodically in forms useful to those who need them, are a fundamental tool for appraising the effectiveness of child-labor laws and other legislation intended to protect the health and safety of young workers. Especially desirable are statistics showing injuries to minors illegally employed separately from those occurring to minors legally employed. Statistics on those illegally employed would indicate where the enforcement of the present laws protecting young workers needs to be strengthened. Statistics on those legally employed would give clues as to how the existing laws or regulations need to be improved in order to prevent children from being employed on jobs that are too dangerous for them. They would also be useful in determining which jobs are so hazardous that employment in them ought to be forbidden for minors who are old enough for general employment. This would be especially helpful in those States in which a State agency has been given authority to prohibit the employment of minors in especially dangerous occupations.

For case stories of industrial injuries to minors illustrating specific accident and health hazards, the individual report of injury is usually the best primary source of information. Such a report is ordinarily required for every industrial injury within the scope of the State workmen's compensation law, and is filed with the State compensation administration by the employer or insurance company soon after the injury occurs. Some States publish descriptions of injuries to young workers from time to time, basing them on actual cases reported in this way to the compensation officials. These stories are particularly valuable when the formal report of the injury has been supplemented by investigation as to the age of the minor, the legality of his employment, the circumstances responsible for his injury, and the degree of disability that is likely to result.

In addition to being one of the basic sources of industrial-injury stories and statistics, the individual report of injury is also valuable in that it furnishes a point at which efforts to prevent similar injuries to minors in the future can best begin. Some States now try to accomplish this goal by having all incoming reports of injuries to minors reviewed by the several divisions or agencies responsible for the enforcement of various types of protective legislation. The child-labor office examines them in order to verify the age and legality of employment of the injured child and to take necessary action if the work is found to be illegal. The accident reports for minors may also be reviewed, along with those for older workers, by the persons responsible for enforcing safety and industrial-health laws, who also take remedial action, if necessary. The workmen's compensation administrators see that the proper amount of compensation is paid, including penalty compensation for illegal employment, if it is due. The statistical services compile the tabulations needed by the various agencies or divisions involved and, in cooperation with them, interpret the resulting data for their use and for that of the public.

Each of the 47 States having a workmen's compensation law possesses the fundamental data for studying its own experience in regard to industrial injuries to minors. By utilizing the statistical and other information latent in the individual accident reports, each State can find out what problems are involved, and what solution is indicated. Intelligent and effective action can then be taken to save the lives and limbs of young workers.

Stories Behind the Statistics

Ten-year-old hurt in fall from bakery wagon.—A 10-year-old boy employed as part-time helper on a bakery wagon fell to the pavement, injuring his hand, one foot, and both shoulders. His wages were reported as $1 a week. It was expected that he would be disabled for 3 or 4 weeks. His employment was illegal under the child-labor law of his State.

Killed by pulp rolls.—A 16-year-old boy was instantly killed when he was caught between the rolls on a pulp machine.

Crushed between trucks.—A 15-year-old boy was severely injured by being crushed between two trucks at a plant where he was employed as a driver.

Arm mangled in laundry machinery.—A boy aged 16 years had his arm mangled in an extractor in a laundry.

Portable sawmill accident.—A 15-year-old boy was seriously injured when caught in the tractor belt of a portable sawmill operating on a farm.

Death from skull fracture.—A 17-year-old high-school boy was injured while loading cars at a steel plant, but insisted he was not seriously hurt. He had, however, sustained a fracture of the skull and was fatally stricken at the high school while waiting to receive his diploma.

Killed in shipyard.—A 16-year-old boy employed as a laborer by a shipbuilding company was helping repairmen work on his slotting machine, which was out of order, and for this purpose got under the machine. A plant "jitney" struck a stack of 500-pound castings near the machine and knocked them over on the boy. He was killed instantly.

Meat-grinder accident causes loss of hand.—A 15-year-old boy employed in the meat department of a chain store lost the greater portion of one hand in a meat grinder. Police and hospital staff men worked for 2 hours cutting away the head of the meat grinder to release the boy's four hopelessly crushed fingers, which were later amputated. His work on the meat grinder was a violation of the child-labor law of his State.

Thirteen-year-old farm hand injured in fall from thresher.—A 13-year-old boy employed as a farm hand by a threshing contractor fell from a thresher and broke his collar bone. His employment was illegal under the child-labor law of his State, and his employer had to pay him treble the normal compensation rate on this account.

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CHILDREN AROUND THE WORLD

BRAZIL

Welfare Services for Juvenile Delinquents

Under a recent decree, the "Service of Assistance to Minors" (Serviço de Assistência a Menores), a unit of the Ministry of Justice and the Interior of Brazil, has been reorganized, and its functions have been expanded.

The Service has heretofore been investigating the cases of children brought before the juvenile court in Rio de Janeiro and maintaining institutions for them. Under the new decree the facilities of the Service are made available to any juvenile court in the country. The Service is to study the cases of children referred to it by juvenile courts; to provide physical and mental examinations and treatment for them; to watch their progress in institutions and to take measures for their rehabilitation after discharge from institutions; to supervise public and private institutions for neglected and delinquent children; and to study the causes of neglect and delinquency.

Two new institutions, one of them a hospital, have been added to those previously maintained by the Service of Assistance to Minors.

The Service will also conduct courses for the training of its staff.

Several new positions are to be created, and appropriations for the salaries are to be included annually in the budget of the Ministry of Justice and the Interior.

Diario Oficial, Rio de Janeiro, September 13, 1944.

MEXICO

Institution for Tuberculous Children in Mexico City

The "First Shelter for Tuberculous Children" has just been opened in Mexico City. This institution, established by the National Committee Against Tuberculosis, is intended for the temporary care of certain categories of children discharged from the Children's Hospital after treatment for tuberculosis. Among others it will accommodate children in the "post-tuberculosis period" who need to be taught habits of hygiene before they are returned to their homes, also children who may still be a source of infection to members of their families, and children who may be in danger of being reinfected in their homes.

In connection with the opening of the institution the National Committee Against Tuberculosis has inaugurated a campaign for the sale of seals and certificates.

El Popular, Mexico City, March 15, 1945.

Plans for Low-Cost Housing

Plans for low-cost housing have been made in Mexico City by representatives of the Institute of Social Insurance, which administers the law on social insurance, of the Federal Department of Health and Welfare, and of other Government departments. The Institute will finance construction of houses to meet the urgent need of workers' families.

El Popular, Mexico City, April 9, 1945.

Newsboys and Bootblacks Taught To Read and Write

In response to a recent appeal for the eradication of illiteracy, made by the President of Mexico to the people of that country, the Federal Department of Labor and Social Welfare has formulated a program to teach reading and writing to newsboys, bootblacks, and other boys engaged in street trades. The boys will be taught by teachers employed in the institutions of the Department of Labor and Social Welfare. The teachers are to be organized in groups of five, each group to be directed by one of its members. Records are to be kept of the work.

Special attention is to be given to Mexico City and its surrounding territory, but the work will be gradually extended to other industrial localities.

Trabajo y Previsión Social, Mexico City, September 1944.

CHILE

First Pan American Congress of Social Service

The First Pan American Congress of Social Service will be held in Santiago, Chile, in September 1945. The time has been planned to coincide with the twentieth anniversary of the founding of the "School of Social Service of the Board of Public Welfare of Santiago", the first school of social service in the Latin-American nations.

The agenda of the Congress includes such subjects as social-service training and social service in child welfare, industry, and rural localities.

The Congress will be held under the auspices of the Ministry of Health of Chile.

Boletín No. 1 del Primer Congreso Panamericono de Servicio Social.

RUSSIA

Administration of Law on Mothers' Aid

For the administration of a law passed July 8, 1944, which provides for increased financial aid to mothers and for an extension of maternal and child-health services, a Federal bureau has been established in Moscow in the People's Commissariat of Finances of the U. S. S. R. Six thousand branches of the bureau have been organized throughout the country. Action on the mother's application for aid is reported to be taken by the municipal authorities within 2 weeks from the time of its receipt.

Similar bureaus have also been established in the Baltic republics recently freed from the Germans.

Izvestia, Moscow, March 4, 1945.

Parent Education

Courses of lectures for parents have been given in many cities and rural districts of the Don Province, U. S. S. R. Exhibits on child training have been set up in clubs and public reading rooms.

Pravda, Moscow, December 18, 1944.

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UNRRA Works for Children

The Bridge Between Today and Tomorrow

Learning About Child Labor

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The photograph on the cover, of children returning to school, by Philip Bonn, is used by courtesy of the U. S. Office of Education.

U. S. DEPARTMENT OF LABOR
L. B. Schwellenbach, *Secretary*

CHILDREN'S BUREAU
Katharine F. Lenroot, *Chief*

ONE MORE CHANCE!

Postwar planning has occupied much of our thought in recent months. Much of it has been concerned with physical and economic problems; some of it with more personal needs. Action to achieve the goals for the next 10 years, set in 1940 by the White House Conference on Children in a Democracy, was greatly retarded by war necessities. Some of the recommendations of that conference were translated into postwar terms in the recent report of the National Commission on Children in Wartime, called "Building the Future for Children and Youth."

Now, with dramatic suddenness, we *are* in the postwar period. Thanksgiving for victory and the opportunity that victory has placed in the hands of the free peoples of the world must lead us to the resolve that never again shall the horrors of war be unleashed upon mankind, for if they are it will mean the destruction of civilization. We have the scientific knowledge, the technical and managerial skill, and the material resources to work out ways of life upon this small planet that will mean peace, plenty, and opportunity for all. But do we have the insight and the character, the conviction and the dedication, to use these resources for such a goal? Can we so guide and educate our children that they can be trusted to use the secrets of the universe for the welfare and not the destruction of humanity? If we and our children, the children of this generation, fail, our material resources and the gadgets our science has produced will crumble into dust and we, too, will become a defeated Nation, or more likely, a people utterly destroyed.

We know some of the first steps to take in preparing our children for the power they will hold in their hands, for they have been well-charted. We know that physical, intellectual, and emotional health and maturity are usually interdependent. Into the development of a whole man or a whole woman go all those things that signify health in all the areas and relationships of life.

For our children, economic opportunity and social security for the family, good homes and parents of intelligence and character, and community services and opportunities for their health, education, recreation, and welfare, the best that our minds can devise and experience can teach, are essential. These are definitely the concern of Government as well as of individual parents. In addition, the resources of religion are needed as never before, religion that will help to tie together the peoples and races of the earth.

We have spent ungrudgingly 2 billion dollars for the atomic bomb. We shall spend other billions in discovering and harnessing atomic energy to the pursuits of peace. Dare we fail to spend whatever may be required for the rearing and education of the human beings who will use this energy? The time is here to invest whatever is needed to assure the best opportunities for children and youth this world has ever known, for they must exercise choices and carry responsibilities unforeseen in human history. Such opportunity for every child, regardless of race, creed, color, residence, or economic circumstance, can be achieved only through the combined efforts of parents, community agencies, and Federal, State, and local Governments. Moreover, international cooperation in behalf of the welfare of children is one of the best means of promoting international understanding and friendship.

The next few years will tell the story of whether this is the birth of a golden age or the prelude to destruction. We have this one chance. Let us use this one chance well.

Katharine F. Lenroot

Katharine F. Lenroot
Chief, Children's Bureau

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UNRRA WORKS FOR CHILDREN

Photograph by UNRRA

KINDERGARTEN OVER, Ante Peruvici takes his teddy bear for a ride in the fine trolley that has been made for him in UNRRA's refugee Camp Tolumbat, Egypt, from salvaged wood. Three other sturdy youngsters—all kindergarteners—accompany him for his voyage across the sandy ground that forms Tolumbat, chosen for its fine temperate climate and its pleasant situation on the sunny shores of the Mediterranean Sea.

Its Success Depends Both on Member Governments and on People With Resources to Share

by MARTHA BRANSCOMBE

Chief Child-Welfare Specialist United Nations Relief and Rehabilitation Admiinstration

Throughout the years of war the United Nations have recognized that the task of alleviating the distress of victims of war is a matter of common concern calling for international cooperation. Consequently the United Nations Relief and Rehabilitation Administration was created as an international instrument to assist the United Nations in meeting the emergency needs of their respective countries where their own resources were inadequate. Through many long months and with the expenditure of large sums of money UNRRA has made plans and preparations to fulfill its responsibility to bring immediate relief to victims of war in liberated areas. Today in the light of the appalling needs of children in Europe and in the areas of the Pacific, we are justified in asking to what extent these plans and preparations have been effectively put into operation.

In reviewing or evaluating the activities of UNRRA it is essential to bear in mind the limitations within which UNRRA is authorized to operate. In brief, UNRRA is authorized to undertake emergency relief activities in behalf of victims of war in liberated areas only upon the request of the recognized government of the country concerned or the military authorities in control. The activities undertaken in such areas are limited to those set out in an agreement made between UNRRA and the government concerned or the military authorities in control. Thus it is clearly recognized that primary responsibility for relief and reconstruction is vested in the people of each country and that UNRRA can assist in the emergency stages only to the extent that the country cannot meet its own needs and only in such ways as the country desires.

Two major aspects of UNRRA's activities up to the present time which have important implications for children, namely, those concerned with estimating and procuring essential relief and rehabilitation supplies and those concerned with essential health, welfare, and other technical services. While UNRRA is prepared to assist any member government with the procurement of relief supplies, it was never intended that UNRRA should provide free relief supplies for countries which had sufficient foreign-exchange resources to purchase their own supplies. Most of the western European countries, such as France, Belgium, the Netherlands, and Luxembourg, always expected to purchase and pay for their own supplies. UNRRA's attention has, therefore, been focused mainly upon obtaining relief supplies for such countries as have suffered devastation and disruption so extensive that their foreign-exchange resources are exhausted and they cannot go into the world markets and purchase their full import requirements. These countries include Greece, Yugoslavia, Poland, Czechoslovakia, and Albania, among others. In the case of these countries UNRRA has entered into agreements with the recognized Governments and is currently operating in each of these areas in accordance with these agreements. The stage of development of the UNRRA program in these countries varies according to the duration of the military period and the nature and scope of activities called for in the agreement between UNRRA and the Government of each country. In the Far East UNRRA's activities have not reached the operational stage. In anticipation of the great need that will emerge in China and other Far Eastern areas, however, UNRRA is working closely with the Governments concerned in developing plans that can be put into operation without delay.

UNRRA activities global

It is impossible in this brief account to run the whole gamut of UNRRA activities, which are global in scope. To the American people, nevertheless, it is of vital concern to know what UNRRA is actually doing today for children in some of the liberated countries and for children of United Nations nationalities who have been displaced outside of their own countries. It should be borne in mind that while UNRRA is prepared within the limits of its resources to assist the liberated countries with any type of emergency service, including technical and professional personnel, or supplies required for children, its actual operations are determined by what the civilian Government of each country requests or, in the case of areas under military control, by what the military authorities in command request. As a result the programs for children vary widely.

In accordance with one of its basic policies, UNRRA works through existing national and local child-welfare organizations or other established welfare services with a view to strengthening or helping to reestablish services which normally provide care for children. Where emergency conditions call for the establishment of new emergency services, primary consideration is given to assisting the people themselves to undertake these programs. Thus UNRRA personnel does not deal directly with individual children or set up its own services to duplicate those already existing. There are two exceptions to this principle of operation. One is in the case of children of any of the United Nations who have been displaced outside of their own country and have been cared for in refugee camps in the Middle East. The second exception affects displaced children found in enemy territory where UNRRA has been assisting the military authorities in their care and repatriation in accordance with an agreement between Supreme Headquarters Allied Expeditionary Forces and UNRRA. Even where UNRRA has provided directly for the care of displaced children, every effort has been made to help adults to provide the services and direct care for the children.

During the military period in Greece UNRRA personnel functioned as agents of the military authorities in providing emergency civilian relief. On April 1, 1945, the military ceased to function in this connection and UNRRA assumed full responsibility for relief and rehabilitation in Greece in accordance with an agreement with the Greek Government. Two experienced child-welfare specialists are on the headquarters staff of the UNRRA Mission in Greece. These specialists give consultation services to the Greek Ministry of Social Welfare and other child-welfare agencies, both official and voluntary. They also give technical assistance to UNRRA's field personnel and regional welfare officers in Greece.

Coordination of services

Through the assistance of UNRRA, the Ministry of Social Welfare has undertaken to organize its own Children's Bureau, through which it plans to coordinate all welfare services and programs for children. A Technical Committee on Child Welfare was set up by the Ministry with the assistance of UNRRA, which has brought together representatives of all major organizations in Greece, both official and voluntary, concerned with the care of children. The main object has been to insure close coordination in the planning and operation of services for children. This committee has from time to time appointed subcommittees to deal with special problems. One subcommittee, appointed to consider the urgent need to reopen vacation colonies for debilitated children, prepared a statement of minimum standards for such colonies. Through the committee's efforts, with supplies and technical guidance from UNRRA, such colonies have been open for the past 2 months and will care for 35,000 children for 3-week periods.

Foster-home placement

Another subcommittee is currently developing a program for homeless children, who constitute one of the most urgent problems confronting the Greek Government. As a consequence of the work of this subcommittee the decision was made by the Government to institute a program of foster-home placement for the care of orphan children rather than to begin building new orphanages besides those already there.

UNRRA has been assisting in a survey of children's institutions in Greece, which is intended to serve a number of purposes: To ascertain the number and identity of children currently cared for in existing institutions; to facilitate plans to place as many of these children as possible in family homes; to locate children who are lost or are separated from their families; and to ascertain what supplies and equipment will be required to refurnish these institutions and to assure the best possible care for children remaining there.

In addition to this type of service, UNNRA is concerned with estimating and procuring needed supplies and assuring their fair distribution to restore Greek children to health and normal development. This covers food, clothing, household furnishings, and shelter.

The program in Yugoslavia presents a totally different picture from that in Greece. The Yugoslavian Government requested assistance primarily in the form of relief supplies. In accordance with the agreement between this Government and UNRRA, the Administration began operations on April 15. As one of the major problems confronting Yugoslavia is the care of approximately 500,000 homeless children, a child-welfare specialist has been placed on the UNRRA mission staff to assist the official national organization concerned with child care in preparing estimates of the supplies needed immediately for these children. In addition to this assistance, UNRRA has undertaken to rush special food supplies for children by plane into certain areas of Yugoslavia where conditions were extremely serious and which could not be reached otherwise because of lack of transportation. Reports from the child-welfare specialist on this mission emphasize the excellent caliber of the Yugoslavian personnel and the capacity of the established services to handle their own programs if given supplies.

In recent weeks the first contingents of UNRRA personnel have gone to Czechoslovakia and Poland, where plans are being developed.

Although Italy is not a member of UNRRA, by special action of the UNRRA Council at its second session in September 1944, the sum of 50 million dollars was allocated for a limited relief program exclusively for children, mothers, and displaced persons. The program developed in Italy is intended only to supplement the basic relief program operated by the Italian Government and the Allied Control Commission and the services normally provided by Italian agencies. Primary consideration has been given to supplementary feeding for children and expectant and nursing mothers.

The feeding program has been developed through the organization of Provincial Committees which in turn work with existing groups in the communes and villages. Beginning in April 1945 with five of the most devastated provinces and the Rome and Naples areas, the program had been extended by July 30 to include most of the needy mothers and children in 28 of the 49 provinces currently under the jurisdiction of the Italian Government.

Wherever possible the feeding program is operated as a school lunch program, but in some of the more devastated areas hot meals are prepared in convents or other places and served in temporary classrooms. If no facilities are available for preparing food, arrangements are made for distributing unprepared food for home consumption. In the latter instance distribution is based on medical examinations. Through school lunches and other centers, over 400,000 mothers and children were receiving daily meals in July 1945.

In the city of Naples, during June, over 20,000 children were being fed through 33 city elementary schools. In order to continue the feeding program, schools have re-

ITALIAN CHILDREN, mothers, and United Nations refugees, displaced from their homes by the war, are receiving UNRRA medical care and services, one of which is X-raying to detect tuberculosis tendencies, especially among children. Here one such little girl, assisted by her mother and the UNRRA nurse, is X-rayed. She is one of 1,000 persons examined in one week at this UNRRA medical center in Cinecitta, Italy. The X-ray machine was imported to Italy by UNRRA for use with these relief programs.

Photograph by UNRRA

mained open during the summer months.

Diverse groups help

The Rome Provincial Committee for UNRRA Relief, assisted by the welfare division of the UNRRA mission, started an emergency school-lunch program on June 11. By July 30 it was feeding 45,000 children in 153 schools in Rome and its suburbs. As in Naples, this scheme has made it possible to keep the schools open for the 3 summer months. The Commune of Rome is contributing one-third of the cost.

UNRRA assistance in this undertaking has drawn the cooperation of representatives of many diverse groups. The Rome Provincial Committee consists of representatives of the Vatican, and of all important Italian welfare organizations and women's organizations, as well as governmental and educational authorities. The Prefect of Rome, Dr. Giovanni Persice, chairman of the committee, has worked closely with the Director of the Welfare Division of UNRRA in this project.

Juvenile "vagrancy" is an extremely serious problem in Rome and Naples. It is expected that this cooperative effort to alleviate the food situation will have an important effect in keeping children off the streets of both cities by attracting them back to school. It is also hoped that a precedent will be set for an all-year-around school-lunch system operated by the local government and that recreational and educational summer programs will be begun along with the food program.

As the condition of children in institutions has been found critical, a survey of the child-caring institutions is in process. Meanwhile, in addition to the children fed at school, more than 12,000 children in 200 institutions within the Naples region, which includes almost every residential institution for children in Naples Province, and 16,000 children in 280 residential institutions in the Rome region are receiving milk and other foods supplied by UNRRA.

Considerable quantities of clothing and shoes have been sent forward. Special health services, which include nutrition services, tuberculosis X-ray clinics, and malaria control have been developed.

Another type of service which UNRRA has provided for children is illustrated by the request for expert consultation services from the French Ministry concerned with the repatriation of displaced French people. UNRRA is not operating in France, as this country is fully prepared to operate its own emergency services. However, at the request of the Ministry of Repatriation UNRRA sent its Chief Child-Welfare Specialist to confer with the French authorities on some of the complex problems of registration, identification, and care of displaced children who had for various reasons become separated from their families. Through this type of consultation UNRRA has been able to coordinate its plans for the care and repatriation of displaced children in other countries with provision for the care of children found in France.

Temporary care provided

UNRRA has provided temporary care for thousands of these children displaced outside their own countries in refugee camps in the Middle East, for which UNRRA assumed responsibility in 1944 and which were previously operated by the Middle East Relief and Refugee Administration. While most of these children were accompanied by some member of their own family or a relative, some were completely alone. Most of these children were of Greek or Yugoslav origin, though other nationalities were included in smaller numbers. Today these children as well as the adults are rapidly being returned to their homes.

During recent months, UNRRA has provided personnel to assist the military authorities in the American, British, and French zones of occupation in Germany and Austria in the care and repatriation of millions of displaced persons. UNRRA personnel has been supplied in the form of teams, including welfare, nursing, and medical officers. Up to the end of July over 300 such teams had been sent to assembly centers in Germany.

Operations up to the present time have been undertaken at the request of the military authorities in accordance with an agreement between Supreme Headquarters, Allied Expeditionary Forces and UNRRA. This agreement contemplated that UNRRA would eventually assume full responsibility for this operation in the zones of Germany and Austria occupied by the American, British, and French Control Authorities. Negotiations are now in process which look toward UNRRA taking over the displaced-persons operation at an early date.

Specialists recruited

Meanwhile UNRRA's plans have encompassed special care and protection for children, and specialists have been recruited to assist in all phases of the program. Many of these specialists have already been sent forward as welfare officers on the UNRRA teams, and one specialist is attached to the Displaced Persons Branch of SHAEF.

Until now it has been impossible to determine the exact number of displaced children actually in the assembly centers in Germany, or to estimate the number not yet discovered. While exact figures are not available, it appears that in general children make up from 5 to 10 percent of the population in the assembly centers. The welfare officers on the UNRRA teams working in the centers have sent back interesting reports on the kind of activities and services being undertaken for children even in these temporary communities. Most of the work is being done by the displaced persons themselves, who are grouped according to nationality as quickly as they can be sorted out. Despite limited supplies and equipment, there are exciting accounts of setting up day nurseries, nursery schools, kindergartens, elementary schools, and other types of activities for children in the assembly centers, through which many of these children are having their first contact with a democratic way of life.

UNRRA has made arrangements in advance with such countries as Sweden and Switzerland to receive for temporary care children who cannot be adequately cared for where they are found or who need special treatment pending repatriation. Approximately 350 children have been removed from the Buchenwald concentration camp for care in Switzerland. This country is prepared to give temporary care to at least 2,000 of these children if necessary. It is expected that 1,000 will be sent to Sweden.

One of the most difficult problems is presented by the unaccompanied child who is without identity. While it is expected that their number will be small, the importance of protecting the rights of these children and of their families cannot be overemphasized. UNRRA considers its first responsibility is to try to establish the identity of these children and to locate their parents or relatives.

Children are truly the most tragic victims of this war. Basic to all essential services for them is the whole question of relief supplies and transportation facilities. Without milk, sugar, cereals, medical supplies, clothing, and fuel, there is little hope that UNRRA, the countries themselves, or any other authorities can avert the catastrophe that threatens not only child life today but our whole future civilization.

UNRRA was created by the United Nations. Its effectiveness in alleviating distress and assisting in the gigantic task of salvaging children from the scourges of war is in large measure dependent upon the support and cooperation of member Governments and the people of the countries possessing the vital resources required for the fulfillment of its responsibilities. The fine spirit of cooperation and the humanitarian feelings which motivated the creation of UNRRA offered great promises to the children of liberated areas. To the extent that resources are made available to UNRRA and that the countries themselves recognize the needs of their children, UNRRA will fulfill those promises. At the same time it must be remembered that UNRRA is limited to emergency relief. Vast numbers of children will require continued care and specialized services for long periods. We cannot, therefore, forget today that our common interests not only call for common action in these first emergency stages, but extend beyond and into the future.

The Bridge Between Today and Tomorrow

When the Director of War Mobilization and Reconversion made his quarterly report to the President and the Congress, released July 1—just 44 days before the collapse of Japan—he had significant remarks to make on some of the human needs that must be met if the road we take in peace is to carry us to the "ultimate goals of a world of durable peace and an America of unprecedented prosperity." Because of their interest to workers in social-service fields, we excerpt some of these statements here:

"The United States is a country of enormous physical resources. Yet its greatest asset—the ultimate source of all its vast wealth—is people. Unless we take proper measures to give every child the right start in life—through education and adequate medical facilities—we are guilty of wanton waste.

* * *

"* * * we shall want to enjoy some of our increased national income in the form of increased public services.

* * *

"* * * An adequate unemployment compensation law is our number one legislative requirement for reconversion."

* * *

"We need to consider broadening the coverage of unemployment compensation; old-age and survivors' insurance; the provision of sickness and disability benefits; provision of better medical care; the institution of more adequate grants-in-aid to the States for hospitals and health centers; and better equalization of educational opportunities.

"Social security is vital not merely as a humanitarian but as an economic policy. Adequate protection against the major hazards of modern society is a necessary factor in maintaining mass purchasing power, which in turn is the basis of full employment.

* * *

"Only if we have a large shelf of public works in the blueprint stage will we be able to quickly get a building program under way. Under such conditions speed would be of utmost importance to quickly provide interim employment to get our economy on the upgrade again, in the event that mass unemployment develops before business has had time to reconvert."

* * *

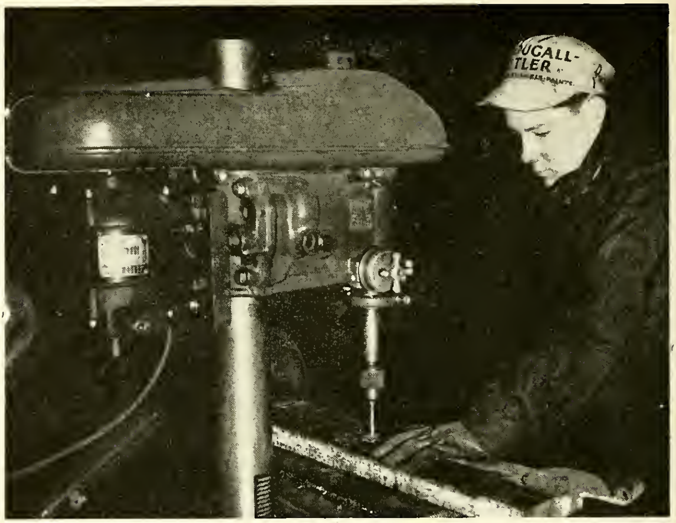
"Food is a prime requirement in liberated Europe. Generally speaking, a grown person needs about 2,000 calories a day to subsist and considerably more—some 2,600—if he is to do active work. But Greece can produce only enough food to supply 970 calories for its people, Albania, 1,015, Norway, 1,115, the Netherlands, 1,630, and Belgium, 1,795. To provide even a bare subsistence diet, these and other liberated countries must supplement their domestic food supplies with imports.

"Computing our calorie supply by the same methods used for Europe, each person in the United States will have an average of 3,050 calories a day this year, about the same as before the war. And a relatively small amount of food from us can mean a great deal to Europe. For example, if the United States were to cut down its calorie supply by only 8 percent it would be enough to increase the daily supply of the above five food-poor countries by more than 80 percent and give them the 2,600 calories a day needed for an active population."

* * *

For copies of the OWMR Director's quarterly report, "The Road to Tokyo and Beyond," write to the Office of War Information, 1400 Pennsylvania Avenue, Washington 25, D. C.

A SHINY NEW MACHINE like this one may be fascinating to a boy, but it is not necessarily a safe one for him to operate. To protect boys and girls from hazardous work Congress has included child-labor provisions in the Fair Labor Standards Act of 1938.



Photograph by National Youth Administration

LEARNING ABOUT CHILD LABOR

Child-labor clinics help employers understand the whys of legislation for young workers

Part of the tremendous increase that has taken place in the number of violations of the child-labor provisions of State and Federal laws is a result of lack of knowledge concerning these provisions on the part of employers who had not been employing young people in any great number prior to the war period. In order to call these provisions to the employers' attention and also to make clear to them what is happening to young people who are employed, either legally or illegally, the Children's Bureau has been encouraging and helping groups of employers to hold conferences, usually known as child-labor clinics, in many cities throughout the country. A number of these were held in the late spring and early summer of 1945, before the schools were closed for the summer.

The first step is usually to present the idea of the clinics, with emphasis on the educational approach, to officials in the State departments of education and labor and to other officials interested in the employment of minors. After the Bureau has been given assurance by the State officials that they will cooperate in the program, the cities in which the clinics are to be held are visited by the Bureau's child-labor consultant or the United States Department of Labor field assistant on information services, representing the consultant, to make plans with the local representatives of the departments and with local groups of employers. Because the meetings are for employers they are usually sponsored by the local chamber of commerce or by one of the employer groups. In some places service clubs such as the Lions Club either sponsor the meeting or join with the chamber of commerce in sponsoring it. Since representatives of the United States Employment Service and the War Manpower Commission place young people in jobs and therefore need to know the child-labor provisions of the Federal and State laws, these officials are also consulted and invited to attend the clinics.

In some areas local trade unions participate in the employers' clinics, and in some separate meetings for labor representation are arranged.

How the Clinics Are Organized

The purpose of the clinics is to explain the child-labor provisions of the Federal and State laws and to give information on how minors may obtain employment certificates or working papers in order to be legally employed. There are luncheon meetings, dinner meetings, afternoon meetings, and evening meetings. (One was held in the morning as part of a day's program, when employers had come together to get information on National War Labor Board policies.) The custom in the community where the clinic is held usually governs the time of day chosen.

The plan of the meeting is to have a short introductory speech by a representative of the Wage and Hour and Public Contracts Divisions, which emphasizes the great rise in the employment of minors, as shown by the large increase in child-labor violations; this is followed by a talk by the child-labor consultant of the Children's Bureau, summarizing the child-labor provisions of the Federal laws. The State laws and the employment-certificating procedures are explained by representatives of the State labor and education departments. These talks point out the large number of minors leaving school and frequently include a plea for sending young people back to school.

Because questions are an important part of the sessions the talks are kept short, so that the whole period of set speeches does not take more than 45 minutes on the average. The sponsoring organization in some places has asked its members to write questions, which are then given to the speakers to be answered. These questions include no identifying information and cannot be connected with any firm. It is emphasized that the meetings are intended to give employers information and not to get information on which to base inspections of firms. Not only has there been active questioning at the meetings, but employers have often gathered around the speakers after the meeting and asked questions.

Child-labor material, both State and Federal, is placed on a table after the meeting. This is done at that time so that the employers need not take notes on the provisions of the laws during discussion. They can take the summaries with them.

Attendance and Publicity

The attendance at the meetings that have already been held has been very good, ranging from 50 to 185 persons. The local chamber of commerce or other sponsoring group has sent out notices to their members, giving the names of the speakers and urging the members to be present. Although most of those participating in the clinics have been employers, in two cities invitations were sent to social agencies, and many of their representatives attended. In one city more than 15 officers issuing employment certificates attended the clinics, many of them coming from schools in the surrounding rural counties.

Prior to each clinic, releases were sent to the local newspapers, and at the time of the meeting copies of excerpts from the talks were distributed to reporters who came. The resulting publicity on the Federal and State child-labor laws had the additional value of helping the community know the child-labor requirements better.

Apparel Industry

Representatives of several associations of employers in the apparel industry came to a special meeting for them held in the regional office in New York City. This was probably the first child-labor clinic ever to be held with employers in a single industry. The associations represented about 8,000 employers, and they were very much interested in the child-labor regulations. The same type of program used in the other clinics was given, but with local speakers. A local city-school issuing officer told how young workers might obtain employment certificates and what plans had been developed to handle the usual rush for summer certificates. At this meeting the child-labor consultant presented a special summary of how the child-labor laws applied to this industry, originally prepared at the request of one of the associations for its membership. Most of the representatives of other associations attending wished to use it to inform their own members.

Results

Judging from the interest shown by all attending child-labor clinics, it is believed that they have been well worth while and have demonstrated a very effective educational technique in administration of child-labor laws. Employers and issuing officers of the local schools have more definite information about the child-labor regulations. If they find a problem at a later date, they know where to go for the solution.

The value set on the conferences by community representatives was voiced by a social worker who attended one of the clinics, who said that "it was epoch-making for the city that employers, including all types of industrial and mercantile establishments, could have the child-labor provisions of the State and Federal laws explained to them in such a clear, concise way."

When employers, as well as the general public, know more about methods of safeguarding the employment of minors, we may be sure that there will be greater opportunities for better education and health of young people, upon whom depends the future of the Nation.

Belt-and-Buckle Factory Owner Fined for Child-Labor Violation

Recently the owner of a factory where 20 children under the age of 16 were employed making belts and belt buckles for interstate commerce was found guilty in a Federal district court of violating the child-labor provisions of the Fair Labor Standards Act. The owner was fined $1,000, and the manager, $250.

The belt-and-buckle factory is located on the fourth floor of a loft building, and children had been seen entering and leaving the building, but whenever a child-labor inspection was made no children were seen in the factory.

Finally an arrangement was made by which four child-labor inspectors were to visit the factory at the same time. One went to the plant office to talk with company officials, while the other three were stationed at the three exits—a freight elevator, a passenger elevator, and a fire escape—through which it was believed that the children were accustomed to leave, upon a signal from the employer or his representative, whenever an inspector appeared.

As was expected, as soon as the officials saw an inspector enter the office, the children made for the exits, but inspectors barred the way.

Of the 20 children who were employed under the legal minimum age of 16, 1 was only 13 years of age when he was hired; 7 were 14 years old. Three of the 14-year-olds had been illegally employed from 6 months to a year. Twelve of the 20 worked frequently, or constantly, at operating foot presses; most of the others worked as delivery boys.

Secretary Schwellenbach Revokes Wartime Child-Labor Exemption

Secretary of Labor Schwellenbach has revoked a wartime exemption to the 18-year minimum age applicable to girls working on Government contracts under the Walsh-Healey Public Contracts Act.

When increased production was vital to the progress of the war, in 1942, Secretary of Labor Perkins granted this wartime exemption pursuant to authority given in the Public Contracts Act. It lowered the 18-year minimum age for girls to 16—the minimum age for employment of boys under the Walsh-Healey Act—and permitted girls 16 and 17 years of age to work under certain conditions. On June 30, as one of her last official acts, Secretary Perkins had revoked the order, effective October 1, 1945.

The action taken by Secretary Schwellenbach makes the revocation effective earlier, in order to halt employment of 16- and 17-year-old girls as quickly as possible. It provides that girls under 18 years of age may not be employed on contracts subject to the Walsh-Healey Act awarded after September 4, but permits girls 16 and 17 years of age to be employed in the performance of contracts awarded on or before September 4, subject to the conditions set up in the 1942 order.

As a result of the Secretary's order, girls under 18 years of age will be prohibited from employment on contracts awarded on or after September 5, and girls 16 and 17 working on contracts previously awarded must be employed under the terms of the original 1942 exemption order. This order required:

(1) That no girl under 16 years of age shall be employed.

(2) That no girl under 18 years of age shall be employed for more than 8 hours in any one day, or between the hours of 10 p.m. and 6 a.m., or in any way contrary to State laws governing hours of work.

(3) That no girl under 18 years of age shall be employed in any operation or occupation which, under the Fair Labor Standards Act or under any State law or administrative ruling, is determined to be hazardous in nature or dangerous to health.

(4) That for every girl under the age of 18 years employed by him the contractor shall obtain and keep on file a certificate of age showing that the girl is at least 16 years of age.

(5) That a specific and definite luncheon period of at least 30 minutes be regularly granted any women workers under 18 years of age.

(6) That no girl under 18 shall be employed at less than the minimum hourly rate set by or under the Fair Labor Standards Act or the Walsh-Healey Public Contracts Act for the industry in which the exemption is granted.

This order appeared in the Federal Register, August 25, 1945.

Children's Bureau Continues Its Series on Trends in Child Labor

The picture of child labor and youth employment has changed often since a quarter of a century ago, when the Children's Bureau first published figures on employment certificates issued to children going to work. The most recent report in this series, by Ella Arvilla Merritt and Floy Hendricks, published in the Monthly Labor Review for April 1945, shows wartime increases in such employment, caused by urgent demand for workers, high wartime wages, patriotic pressures, and social restlessness.

Employment and age-certificate reports show the trend in child labor and youth employment from year to year rather than a cross section of the actual number of young persons employed at any given moment. The Children's Bureau reports, published periodically, are based on records sent to the Bureau by State and local certificate-issuing officials in nearly all the States and in a number of cities throughout the country. They give not only current information as to trends in child labor by individual States and cities, but also significant facts about the age and sex of these workers, the school grades they have completed, and the industries and occupations in which they work. A reprint of the latest report, and of the prior ones, can be obtained from the Children's Bureau, as well as a separate chart showing the increase in the number of boys and girls 14 through 17 years of age who obtained certificates for employment in 1944 as compared with similar figures for previous years.

Interagency Committee on Youth Employment and Education

An interagency committee composed of representatives of the various Federal agencies whose programs particularly concern young people was set up in April by the Secretary of Labor to consider education and employment problems of young people in the reconversion and postwar periods. The Director of the Office of War Mobilization and Reconversion approved the creation of the committee and the Secretary of Labor arranged for the designation of members by the heads of the Federal agencies concerned. The agencies represented on this Interagency Committee on Youth Employment and Education are the Department of Agriculture, the Office of Community War Services, the Office of Education, the Social Security Board, the War Manpower Commission, and four Bureaus of the Department of Labor: The Children's Bureau, the Division of Labor Standards, the Bureau of Labor Statistics, and the Women's Bureau. The committee, of which Katharine F. Lenroot, Chief of the Children's Bureau, is chairman, is concerned with planning for action to meet the needs of youth, and is considering student aid, counseling services, placement services, work opportunities, and other matters.

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"Education to Promote the General Welfare" will be the general theme of American Education Week 1945, which will be observed November 11 to 17. The observance is sponsored by the National Education Association, the American Legion, the United States Office of Education, and the National Congress of Parents and Teachers, in cooperation with other National, State, and local groups. For further information write to the National Education Association of the United States, 1201 Sixteenth Street NW Washington 6.

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BRITISH REPORT ON CHILDREN BORN OUT OF WEDLOCK

Homes for unmarried mothers and their babies, from which the mother can go out to work, leaving the baby under good care, are recommended by the National Council for the Unmarried Mother and Her Child, in its most recent report.

That these homes might be established by public agencies, either welfare agencies as part of their work for unmarried mothers or local governments as part of their housing plans, is the belief of the Council, which includes in its membership representatives of city and borough governments as well as of private organizations.

Such homes, the report says, might well be suitable for widowed or deserted mothers as well as for unmarried mothers and would help to make the child born out of wedlock less conspicuous since he would be merely one of other fatherless children.

The Council does not in itself have responsibility for any maternity home, but about 70 such homes, public and private, are affiliated with it. A representative of each is a member of one of the Council's committees. Encouragement of accommodations to meet the varying needs of unmarried mothers and their babies has been one of the Council's activities ever since its founding a quarter of a century ago.

The Council also works for reform of legislation affecting children born out of wedlock, encourages local public authorities to use their powers to care for such children and their mothers, and helps and advises individual mothers. It also tries to educate public opinion as to the needs of children born out of wedlock in an effort to promote their well-being and to enable them to attain full and worthy citizenship in spite of the handicap of illegitimate birth.

The need for public education, says the Council's report, is indicated by the fact that the general public, and perhaps a good many nurses and doctors, assume that a baby born out of wedlock should be placed for adoption, and as soon as possible. Those who make this assumption, however, do not recognize the difficulty of fitting the child into the home, nor the need for training and experience in arranging adoptions. They have not fully considered the suffering and unhappiness that may arise if a child is unsuitably placed. The Council states as its own view, that adoption should take place only when the mother cannot care adequately for the child and that adoptions should be arranged only by trained and experienced persons.

Use of abridged birth certificates, which omit any indication of legitimacy or illegitimacy, is recommended by the Council for all persons, with possible use of the full certificate when special circumstances require it.

A difficult question for the Council's legal committee was the nationality of children born to unmarried British servicewomen in foreign countries. Formerly such a child did not have British nationality, but now in such cases a certificate of British nationality will be issued, says the report, to be followed when the child is of suitable age by the taking of the oath of allegiance.

Canadian men returning home for discharge from the armed services and leaving children in Great Britain who were born out of wedlock, it is reported, are making voluntary payments toward the support of these children through a plan of cooperation between the Canadian Welfare Council and the military authorities. This plan has been carried out with the help of the National Council for the Unmarried Mother and Her Child, which acts as the central agency in Great Britain.

Cases of married women who have or expect children by men other than their husbands continue to come to the Council's attention. Often the married couple have never had a home or any normal married life. Often the husband has been abroad for several years. Sometimes the new baby is born into a family of older legitimate children. These cases are extremely difficult, says the report. It seems impossible to lay down any general principle about them.

The American Red Cross has worked with the Council in caring for British dependents of men in the armed forces of the United States, and for some time the Council has acted as a clearing house for British unmarried mothers who have made direct application to the American Red Cross instead of applying to a British agency for advice and financial help. Such cases are now referred to local welfare workers.

The Council reports that it often hears from applicants of many years ago whose children, now grown up, ask advice upon questions of guardianship, change of name, or petition for adoption.

For copies of this 24-page report, the Council's twenty-fifth, requests should go to Carnegie House, Picadilly, London W. 1, England.

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"Films From Britain" is a catalog of British films available in the United States through the British Information Services, 30 Rockefeller Plaza, New York 20.

Among the films of interest to child-welfare workers is "Second Freedom," which is concerned with such subjects as health insurance and housing.

Copies of the catalog may be had from any of its six offices—in New York, Chicago, Hollywood, Atlanta, San Francisco, and Washington, and also from British consular offices in 17 additional cities.

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Half a million British children 12 years old or younger, organized in 300 "junior clubs," have the opportunity to see experimental motion pictures made especially for children, under a program sponsored by the Advisory Council on Children's Entertainment Films, according to the British Information Services, 30 Rockefeller Plaza, New York 20.

HOW POLIO STRUCK IN MALTA

At the end of a severe air-bombing which lasted for more than 30 months, Malta and its neighboring island, Gozo, underwent an epidemic of poliomyelitis, which lasted from mid-November 1942 to the end of February 1943, according to a report by H. J. Seddon and his colleagues in the Quarterly Journal of Medicine.[1]

The epidemic took a heavy toll of children and of servicemen who had been sent to the islands from the United Kingdom, but scarcely touched Maltese adults, whether civilians or servicemen.

A total of 483 persons developed poliomyelitis during the epidemic, which reached its peak when 108 cases were reported during a December week. Of the 483 persons affected, 426 were civilians, 57 servicemen. Of the civilians 422 were under 20 years of age, and 397 were under 5. Eleven of the 57 servicemen died; 15 of the 426 civilians.

Poliomyelitis has been endemic in Malta for many years, the report states, though the annual number of notifications of cases has always been small, and never before has there been an outbreak that could be called an epidemic.

These islands are densely populated—Malta, 2,551 persons to the square mile; Gozo, 1,087.

War conditions had brought about serious overcrowding among civilians in Malta since the autumn of 1940, especially during the months when the intense aerial bombardment drove thousands into shelters, and many other persons whose homes had been destroyed took refuge with friends in outlying towns and villages. Living conditions during the bombing were described by the chief medical officer as follows:

> In the danger areas large numbers of people established themselves in tunnels, basements, crypts of churches. . . . Shelters that had been prepared for temporary occupation during air raids became resident quarters. . . . Families had to be accommodated in schools, old churches, corridors of convents. . . . In some of these places even the most essential sanitary requirements were lacking, and in others the conveniences that had existed were quite inadequate for the number of people that had come to live there. Overcrowding continually increased as more dwelling houses were demolished or damaged.

In spite of the overcrowding among the Maltese civilians, there were only seven families in which more than one child was affected, and none in which there were more than two cases. Also the crowding was much less in Gozo than in Malta, yet the incidence of poliomyelitis was about the same in the two islands. There was little crowding among the servicemen, yet this group proved especially vulnerable. Incidentally, the native servicemen and the United Kingdom servicemen lived and worked in close contact, yet only the United Kingdom men developed the disease.

The food supply in Malta during the bombing became dangerously low; in the more fertile Gozo the food situation was much better. The similar incidence of the disease in the respective islands led the authors to consider lack of food unrelated to the epidemic. Dried milk was distributed to both islands, especially to children and to men in the services, but no connection could be traced between the distribution of the dried milk and the geographical incidence of the disease.

The use of sewage in certain parts of Malta for fertilizing crops suggested the possibility that the disease might have been spread by contamination of the water supply or of crops, but the evidence was against this possibility.

The authors comment on the time of the year at which the outbreak occurred (November to February), saying that this season, though unusual for an epidemic of poliomyelitis in the Temperate Zones, cannot be regarded as uncommon; they cite several epidemics, including one that lasted from February to May in Samoa in 1936, and another that lasted from April to June in Puerto Rico in 1930. In connection with the time of year, the article states that the winter months in the Maltese Islands are cool like an English autumn (15° to 60° F.), with more rain than at any other time of the year. There was rain on more than half the days of the first 3 months of the epidemic (November, December, and January), and there were heavy rains and gales shortly before the outbreak of the disease.

During November and December there was an increase in the incidence of common colds among the United Kingdom servicemen.

The months in which the epidemic took place are a period when flies are less numerous on the islands than at any other time of the year. Furthermore, they were fewer during the time of the epidemic than during the corresponding period of the previous year.

IZED
DRINK
SAFE MILK
& SAFEGUARD
YOUR HEALTH

HEALTH AUTHORITIES of the Maltese Islands could find no relation between the spread of poliomyelitis and any contamination of food during the long period of bombing. Here, as a precaution against milk-borne diseases, pasteurized milk is being distributed after one of the severe air-bombings of Valatta, a city on the Island of Malta.

British official photograph

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[1] Seddon, H. J., T. Agius, H. G. G. Bernstein, and R. E. Tunbridge: The Epidemic of Poliomyelitis in Malta, 1942-43. Quarterly Journal of Medicine, Oxford, England. Vol. 14, No. 1 (January 1945), pp. 1-26.

C. B. Health Notes

Broader Interpretation of Eligibility Under Emergency Maternity and Infant Care Program

A serviceman's wife may apply for maternity care and care for her baby, under the Emergency Maternity and Infant Care program, even after her husband has been honorably discharged, promoted, or demoted, provided she was pregnant at some time during the period when he was in one of the four lowest pay grades of the services or was serving as an aviation cadet. On the same basis, she may apply if the husband and father is a prisoner of war, missing in action, or dead.

This interpretation as to who is entitled to care under the Government's Emergency Maternity and Infant-Care program is in accord with a recent Congressional recommendation designed to make the benefits of this program available to wives who fail to make application for themselves and their infants before the status of their husbands in the armed forces is changed by discharge or promotion.

Heretofore the application for care had to be made while the serviceman was in one of the eligible grades. Now all that is required to establish eligibility for maternity care is proof that the wife was pregnant while he was in one of the eligible grades. The infant in these cases is also eligible for full care during his first year of life. Similarly, if the father of an infant whose mother did not receive care under the program was in one of those grades at any time during the infant's prenatal period or first year of life, the infant's eligibility for care under the program is established.

The greatest effect of the new policy, which is retroactive to January 1945, will be to bring infants of discharged servicemen under the program for the full year in which the infant is entitled to care. The new regulation also clears up a matter about which some confusion has existed, that is, whether widows and their infants are eligible. Under this interpretation they are eligible.

The procedure to be followed in establishing eligibility is simple. The wife has only to show to her physician or other authorized person assisting her in filling out the application form an envelope, or a V-mail letter from her husband; or her allowance card or other official communication dated at a time when he was in one of the eligible grades. If she does not have such evidence the State health department can make inquiry of the appropriate armed service.

Under the Emergency Maternity and Infant Care program, complete maternity care, including medical and hospital service, is provided for wives of servicemen in the four lowest pay grades, and aviation cadets, and medical and hospital care is available for their infants through the infant's first year. Care is provided without regard to race or place of residence or financial status.

Children's Bureau Policy on Safeguarding Information Concerning Crippled Children

In planning for and providing services to a crippled child the State crippled children's agency obtains detailed information concerning the health and personal circumstances of the child and his family. Such information, when obtained by a private physician in the practice of medicine, a clinic, a hospital, or other individuals or agencies that provide medical care, is considered confidential and is carefully guarded against inappropriate disclosure. Several State crippled children's agencies have requested the Children's Bureau to state the policy that is to be followed by them in this matter.

The Children's Bureau believes that it is essential that the crippled children's agency safeguard the use and disclosure of information as to personal facts, circumstances, and identifying details concerning crippled children. Failure to provide such safeguards might deter the parment available to the child under the program. Furthermore, the child must be protected from any publicity that might interfere with his social readjustment to the community. Since the State agency would not be able to control the use of information disclosed to other agencies or individuals, the disclosure of such information might result in conflicting plans for the child and might actually delay the carrying out of essential services.

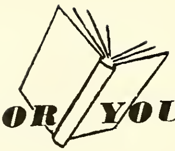
* * *

The problem of safeguarding the confidential nature of information concerning crippled children obtained by State agencies was the subject of discussion at the meeting of the State directors of crippled children's services held in Washington on November 27, 28, and 29, 1944. It was the general sense of the State directors and others attending the conference that in States which restrict the disclosure of confidential information regarding individual crippled children such practices should be continued, and in the remaining States which have no established policy on this matter adequate safeguards should be provided to protect the interests of the crippled child and his parents. It was also felt that the Children's Bureau should state the policy to be followed in this matter so that problems in this regard might be handled similarly on local, State, and Federal levels.

The Children's Bureau has therefore formulated the following policy:

> All information obtained by the State agency in the course of administration of the program as to personal facts, circumstances, and identifying details concerning crippled children under the program, including their medical condition and treatment, shall be held in confidence; provided, however, that such information may be divulged or published under the following circumstances: (a) For purposes directly connected with and necessary for the provision of care and services to such children; (b) in summary, statistical, or other form which does not identify such children; (c) on request of parents or guardians of such children or their authorized representatives; or (d) on request of an officer or employee of the Federal or State Government with official duties and responsibilities related to the administration of the program.

Every State crippled children's agency will be requested to include in its official plan for crippled children for fiscal year 1946 suitable rules and procedures that will restrict the use and disclosure of information as indicated in this policy.



FOR YOUR BOOKSHELF

Psychology for the Returning Serviceman. Prepared by a Committee of the National Research Council. Edited by Irwin L. Child, Yale University, and Marjorie Van De Water, Science Service. Published by the *Infantry Journal*, 1115 Seventeenth Street NW., Washington 6, D. C. 1945. 243 pp. 25 cents.

Addressed to the returning serviceman, this book has interest also for his family and for others interested in human behavior.

Of special interest to readers of The Child are the chapters that deal with family life. Chapter 7, on "Being a father," includes a brief sketch of child development. It interprets what absence of the father may have meant to the young child and the older child of each sex. It describes reactions that the father may observe in the children as well as those that occur in himself, and suggests ways in which to establish or reestablish a sound father-child relationship and to help the child make a good adjustment

Building a Better Southern Region Through Education; a study in State and regional cooperation. Edited by Edgar L. Morphet with the assistance of the coordinators, chairmen, and executive committee. Southern States Work-Conference on School Administrative Problems, Tallahassee, Fla., 1945.

Each year since 1940 the Southern States Work-Conference on School Administrative Problems, which is sponsored by the State departments of education and State education associations of 14 Southern States, has given special study to a limited number of timely educational programs. As these studies were carried out, however, it became more clear that the basic problem that must be faced grows out of the fact that the Southern region has an abundance of resources both human and natural, yet has the lowest level of living in the Nation.

It is evident, says the editor of the report in the foreword, that many of the resources of the Southern region are either being wasted or not properly utilized. If these resources are to be more effectively used for the benefit of the people, the schools and colleges of the region must consciously face the problems involved and carefully plan to assist in their solution.

Because of the importance of the basic problem the Work-Conference has made the comprehensive study reported in this volume, involving all phases of education as related to the resources of the region.

According to the editor, the problems of the South cannot wait on the sponsorship or leadership of the Federal Government or of any other agency outside the South. It is clearly and definitely the obligation and responsibility of the people of the Southern region and of every State in the region to face these problems and to take every possible step toward their solution.

Persons concerned with child labor and with employment programs, particularly in relationship to the responsibilities of the schools, may find of special interest the chapters on "Meeting special educational needs," "Organizing State programs of vocational education," and "The administration of pupil personnel."

Today's Children for Tomorrow's World; a guide to the study of the child from infancy to six, by Aline B. Auerbach. Child Study Association of America, 221 West 57th Street, New York 19. 1944. 24 pp.

This manual for child study, with suggestions for group leaders, is sponsored by the Child Study Association and the American Association of University Women.

Since our only safe prediction is that tomorrow's world will be a changing one, the booklet suggests, let us equip our children to meet changes constructively. It presents outlines for the discussion of such basic questions as what makes a good home, what makes children act the way they do, and how to help children to develop responsibility. Attention is given to special wartime problems encountered in maintaining a good home under changing conditions, in meeting the child care needs, of a community, and in growing up in a democracy. The material is designed to stimulate thought and discussion by parent groups, rather than to provide final answers. A selected bibliography is included with each section.

Patients Have Families, by Henry B. Richardson. The Commonwealth Fund, New York. 1945. 408 pp. $3.

This book deals with the concept that in diagnosis and treatment of illness and in the preservation of health, the family must be considered the unit of illness and the unit of treatment. In presenting his subject the author draws on his individual experience as a physician and on findings and conclusions of the Family Study, "a venture in cooperative thinking about illness in families," which he directed and in which members of the medical, social-work, and public-health-nursing professions participated.

Case material is effectively used to show the stresses and strains of family relationships, characteristic family patterns appearing in illness, and the effect of the family situation on illness.

The author describes the functions and techniques of the medical-social worker, the family case worker and the public-health nurse. He shows how the services of these workers can contribute to the physician's understanding of the family and how medical care becomes more effective through a coordinated plan of treatment utilizing the resources within the hospital and in the community.

This book should be of particular interest to physicians, social workers, public-health nurses, and others concerned with family and social welfare.

Epilepsy—the Ghost Is Out of the Closet. Pamphlet No. 98. Public Affairs Committee, Inc., 30 Rockefeller Plaza, New York 20. 1944. 32 pp. 10 cents.

The story of Helen, a 12-year-old with epilepsy whose parents' attitude with regard to the disease has helped her to live a normal life, is contrasted in the first few pages of this pamphlet with the story of another little girl named Mary, also with epilepsy, whose parents treat her as though she were in mortal danger, and who is developing an immature personality that she will have a hard time correcting later on even though her seizures stop completely.

We now know, the pamphlet says, that a person with tuberculosis or infantile paralysis has an excellent chance of recovering and living normally — provided he has good medical care and that he and his family learn to work hand in hand with the physician. The same is true of epilepsy.

At least 500,000 persons in the United States suffer from epilepsy, and 70 percent or more of patients have the symptoms before they are 20, according to this pamphlet, which includes a simple discussion of epilepsy—cause, diagnosis, treatment, work placement, role of heredity—and steps that should be taken to change the present attitude of society toward the disease.

Foster-Home Care for Mental Patients, by Hester B. Crutcher, Director of Social Work, State of New York Department of Mental Hygiene. Commonwealth Fund, 41 East 57th Street, New York 22, N. Y. 1944. 199 pp. $2.

A family-care program may be developed for two general groups of patients, according to the author. The larger group will include patients, many of them mentally ill, who are not expected to improve much, but who need a moderate degree of physical comfort, a sympathetic caretaker, some freedom to wander about the house and grounds, and simple work or recreation of various kinds according to their interests. The smaller group will include patients who are placed in families as a step toward normal life, with the expectation that the patient will eventually find a permanent place for himself in the community.

The author cites the fact that many low-grade mental defectives who can never be trained to look after themselves either socially or economically, but who are quiet, clean, and pleasant, respond well to the individual attention which they receive in a foster family. The first group includes some of these.

Among the patients in the second group may be some high-grade mentally defective children placed in foster-family care primarily for therapeutic reasons, but also to demonstrate their potentialities for community adjustment in a suitable environment. New York State usually has about 80 children under 16 placed in family care, according to a personal communication from the author.

A chapter of the book is devoted to the subject of selection of patients, another to selection of homes, and another to supervision.

Experience in several States during the past 10 years, says the author, has shown that family care is an effective administrative procedure. It is effective for the following reasons: A large proportion of patients so placed make a relatively permanent and satisfactory adjustment; it releases space for other patients in need of specialized treatment and for those from whom the community needs protection; and it provides care for the patient at less cost than hospital maintenance.

An appendix describes active programs in nine States, and prospective programs in three. The book includes an excellent bibliography.

Suggestions for Leaders of Junior Child-Care Aides. Prepared for the New York State Home Economics Association, 98 Martha Van Rensselaer Hall, Ithaca, N. Y. Leader's packet (four booklets), 35 cents per packet, postpaid. 15 pp. Set of three booklets for students, 25 cents per set postpaid. 32 pp. each.

Leaders of training groups of teen-age girls who are planning to take care of young children in their own homes or in the homes of friends and neighbors should find this packet useful. Besides a booklet addressed directly to leaders, it contains three addressed to girls. Taking Care of a Baby, Taking Care of a Preschool Child, and Taking Care of a School-Age Child. The one for leaders includes an annotated list of 20 books and pamphlets. The three for girls describe activities that children of different ages enjoy and give concrete suggestions that should help to make baby tending a learning experience and not simply a source of extra spending money. Although they are written in simple language they may be difficult for some high-school girls. They are illustrated attractively.

CHILDREN AROUND THE WORLD

MEXICO

School Attendance

The average daily attendance in the public schools of the Republic of Mexico, according to a recent study, is 68 percent of the enrollment. In the Federal District, which includes Mexico City, the attendance is 73 percent.

The reported causes of this deficient attendance are mostly socioeconomic, including lack of food, clothing, textbooks, and other school material; employment of the children; illness; migration of the families; and unsatisfactory condition of schools; also alcoholism of the parents, disorganized family life, and frequent holidays and celebrations of family events. The attendance is also said to have been affected by the teacher's personality, his fitness for the work, and the relations between him and his pupils.

El Popular, Mexico City, April 13, 1945.

Care of Malnourished Children

In the course of an extended campaign on behalf of malnourished children, which began in Mexico City early in the present year under the leadership of the Federal Bureau of Child Health and Welfare, the Federal Government is planning to establish clinics for malnourished children. Each of the clinics, which will be maintained by that Bureau, will have accommodations for 50 children less than 6 years of age. Medical care and nourishing food will be provided. The average stay of each child at the clinic will be 1 month. Admission will be limited to children from low-income families. A nominal charge will be made to those able to pay; others will be admitted free. The children's mothers will be instructed in child care and feeding and will be required to serve a meal to their own children at the clinics at least once a day.

Courses for physicians and nurses in the treatment of malnourished children will be given at the clinics; medical and social studies will be made.

The clinics will cooperate with the Children's Hospital of Mexico City and the 18 health centers maintained in that city and surrounding territory by the Federal Department of Health and Social Welfare.

The work will be financed by the Government and by private persons.

Excelsior, February 9, 1945, La Prensa, January 28, 1945; and El Popular, January 28, 1945; all of Mexico City.

URUGUAY

First National Conference on Social Aid to Youth

The first National Conference on Social Aid to Youth to be held in Uruguay took place in Montevideo in March 1945. The importance of normal family life for the child receiving social aid was emphasized at the conference; also the importance of proper upbringing and education and of vocational guidance and occupational training. Measures for the prevention of delinquency and antisocial conduct were also discussed.

It was decided that the Council of the Child, official national agency in charge of child-welfare work, should forward to the President of the Republic a statement of the conclusions reached by the Conference and point out the measures that need to be taken immediately.

El País, Montevideo, May 25, 1945.

CHILE

Psychiatric Services for Children

A Central Service of Child Psychopathology and Vocational Guidance (Servicio Central de Psicopatologia Infantil y Orièntación Profesional) has been recently established in Chile for the purpose of coordinating all activities on behalf of children with psychiatric or behavior problems. The Service, which is to be a unit of the Bureau of Child Welfare (Dirección de Protección a la Infancia y Adolescencia) is to conduct neuropsychiatric studies of children who have mental disorders, or who present behavior problems, or who are referred to the Service for other reasons by educational or reeducational institutions.

Boletín Médico-Social, Santiago de Chile, January-February 1945.

ARGENTINA

Division of Aid to School Children

A Division of Aid to School Children (Dirección de Ayuda Escolar) is to be set up in the Bureau of Social Welfare of Argentina's Department of Labor and Social Welfare. This is to be done in accordance with regulations recently issued in Argentina for the administration of a law enacted several years ago.

One of the Division's main functions will be the administration of medical and dental care for school children. All school children will be given periodic physical examinations, and children from low-income families will receive free treatment in dispensaries and hospitals and also free medicines. In emergency, or during epidemics, all children will be treated free of charge. The physicians, dentists, nurses, and other staff engaged in this work will be paid by the Government. Measures will be taken to encourage physicians and dentists to settle in rural localities.

The Division is also made responsible for the setting up and administration of school feeding programs for children in need of such service.

The Division has been directed to establish residential schools in isolated localities. During the summer these schools will be used as vacation places for children.

Large quantities of clothes and shoes are to be distributed among needy school children by the Division. The school principals and teachers are responsible for the proper distribution of these clothes and shoes and are subject to penalties in cases of mismanagement.

The funds for this work will be provided from annual appropriations by the national treasury; private gifts will also be accepted.

Boletín Oficial, Buenos Aires, March 24. 1945.

Establishment of Minors' Division

For the purpose of centralizing work for neglected and delinquent youth in Argentina a recent decree by the President of that country ordered the establishment of a Minors' Division (Dirección de Menores) in the Bureau of Social Welfare of the Federal Department of Labor and Social Welfare. The Minors' Division is to take the place of all agencies heretofore engaged in this work, among them the Patronato Nacional de Menores, which since 1931 has had charge of institutions and other facilities for the care of delinquent and neglected children.

The decree also provides for the appointment by the Bureau of Social Welfare within 30 days of a committee of experts for the study of organization on a national scale of welfare work for neglected and delinquent children, juvenile courts, aid to mothers, and related problems. The committee is required to report its recommendations within 90 days to the Secretary of Labor and Welfare.

Boletín Oficial, Buenos Aires, April 17 1945.

Aid to Children in Their Homes

In order to reduce the number of children in institutions and to keep children in their homes, the Minister of Justice of Argentina has recently approved, as a regular policy, the use of public funds for financial aid to families.

Infancia y Juventud, Buenos Aires, No. 31–32, 1944.

•

Among the American Republics that have at least one postage-stamp issue carrying a picture connected with child health or welfare are Brazil, Colombia, Cuba, Mexico, Peru, and Venezuela.

A Message From the Secretary of Labor to America's High-School-Age Boys and Girls

For the last few years you have aided magnificently in one of the great struggles of mankind to preserve justice and freedom. At home and at jobs you have proved that you can concentrate on getting things done.

Now that those tasks have been accomplished, you turn wholeheartedly once more to the greatest privilege that can come to any young man or young woman—a complete education. You will desire to utilize this privilege to the full, so that you can take advantage of the benefits which will unfold in the era of vast development now beginning. You will need every educational advantage you can obtain to fit yourself for the part that you will play in the days and the years to come.

If you are of high-school age, there is no better way in which to serve the Nation and yourself than to enroll in high school, put earnest efforts into your studies, and obtain a diploma. Later, when you go to college or begin a career, you will be thankful that you seized upon this opportunity. For education opens many doors, eases many paths.

I wish you pleasant school years, and hope that you reap all the benefits that education can bring to you.

L. B. Schwellenbach

☆ U. S. GOVERNMENT PRINTING OFFICE: 1945—663565

OCTOBER 1945
VOL. 10—NO. 4

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SEE YOUR DOCT

The CHILD

CHILDREN'S BUREAU • U. S. DEPARTMENT OF LABOR

- Health Services for Children Who Follow the Crops
- Uniting To Improve Health of School Children
- States Raise Child-Labor Standards

VOL. 10 · NO. 4 · OCTOBER 1945

The CHILD

MONTHLY BULLETIN

Editor Miriam Keeler

Assistant Editor Sarah L. Doran

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●

The photograph on the cover, showing a clinic for migratory farm families at a farm-labor supply center was taken by the Office of War Information.

U. S. DEPARTMENT OF LABOR
L. B. Schwellenbach, *Secretary*

CHILDREN'S BUREAU
Katharine F. Lenroot, *Chief*

1945 BACK-TO-SCHOOL DRIVE CLOSES

The recent National Back-to-School Drive sponsored jointly by the Children's Bureau and the U. S. Office of Education of the Federal Security Agency demonstrated once again the happy results which can be obtained, given the combination of a worth-while, realistic goal, effective community work, and adequate publicity support.

Although Nation-wide tabulations of current school enrollment and youth employment are not yet available, reports from several communities in many sections of the country indicate that the downward trend in high-school attendance has been stopped, and that the youth of the United States have caught on to the idea that a high-school diploma is worth more than temporary money.

The Children's Bureau is proud and gratified that it had a part in this worth-while and effective campaign, but it is not unmindful of two facts. First, the rise in school enrollment cannot all be credited to the Back-to-School Drive. And secondly, if any credit can be claimed for the drive it belongs to the individual teachers, fathers and mothers, employers, social workers, counselors, and fellow workers who did the grass-roots work—to the numberless national and community organizations which inspired their local chapters and members to support the drive—and to the State governors and departments and the Federal agencies that cooperated not only by issuing valuable and inspiring statements but by doing practical spadework to enable young workers to return to school without unnecessary financial or other loss.

Generous help was given to the drive by the leading information mediums. At the suggestion of the Office of War Information newspapers, magazines, radio stations, the motion-picture industry, cartoonists, and advertisers gave freely of time, talent, and imagination to speed students back to their peacetime pursuits. Back-to-School messages were heard on 34 prominent network radio programs. The War Activities Committee of the motion picture industry enabled us to reach an estimated audience of 28 million by arranging for Bing Crosby to make a Back-to-School movie short.

A long-range development which comes partly as a result of the drive is evidence of a public demand for continuing efforts to encourage youth to return to school. In one State a public official has already suggested that the drive be extended and that it be broadened to appeal to veterans. In other States school officials have indicated that they plan to continue their Back-to-School activities for at least a month after the opening of school. Child-labor officials will increase their efforts to see that child-labor standards are enforced and work permits properly issued.

These are promising trends. And although the Children's Bureau can neither overstep its jurisdiction by sponsoring an appeal to veterans, nor spare the staff needed to carry on intensive publicity for a year-round Back-to-School drive, we are encouraged that citizens have seen the far-reaching implications of the drive and are eager to continue and expand our efforts.

In the wake of the current interest in this phase of child welfare, the Children's Bureau is confident there will follow increased vigilance to enforce existing child-labor regulations and renewed efforts to obtain adequate legislation where inadequate laws are in effect.

Katharine F. Lenroot

Katharine F. Lenroo
Chief, Children's Burea

Publication of The Child, Monthly Bulletin, with Social Statistics supplements from time to time, was authorized by the Bureau of the Budget May 12, 1936, under Rule 42 of the Joint Committee on Printing, to meet the needs of agencies working with or for children for a regular channe of information on current developments, activities, policies and programs for maintaining the health of mothers and children, providing child-welfare serv ices, and safeguarding the employment of youth. Address The Child, Children's Bureau, U. S. Department of Labor, Washington 25, D. C. The Chi dren's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. The Child i for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at $1 a year; foreign postage, 25 cents additional single copies, 10 cents.

U. S. SUPERINTENDENT OF DOCUMENTS
NOV 24 1945

A CHANCE FOR BETTER HEALTH COMES TO CHILDREN WHO FOLLOW THE CROPS

Government Medical Services Pioneer in Reaching Out to These Forgotten Children

by IONE L. CLINTON
Industrial Division, U. S. Children's Bureau

Hundreds of thousands of migratory farm families follow the crops in the covered wagons of today. They and their children—not only the older children who work but also the younger children and the babies—live under conditions that continue to be far inferior to an acceptable standard of living. These conditions are a menace to their health, to the health of the communities they live in and to the health of the Nation.

How the children live

Usually migratory farm families travel in crowded trucks. Many have to live in and under the trucks for days at a time. Even when housing of a sort is available it also is likely to be makeshift and dirty and to afford little protection against the weather. Often water is hard to obtain and is unsafe to use for drinking purposes. Toilet facilities and methods of garbage disposal are primitive. It is hard for the families to find a place to bathe and to wash clothes. Their food is kept without refrigeration and often spoils. The lack of screens allows flies and other insects to walk on food and sewage alike. Children work long hours in the fields at too early an age because it is difficult for their fathers to earn enough money without their help. When they get sick they usually cannot get doctors and health services because they cannot afford to pay for them, or do not know how to find them.

All these conditions make the migrants especially likely to get sick and give sicknesses a chance to spread.

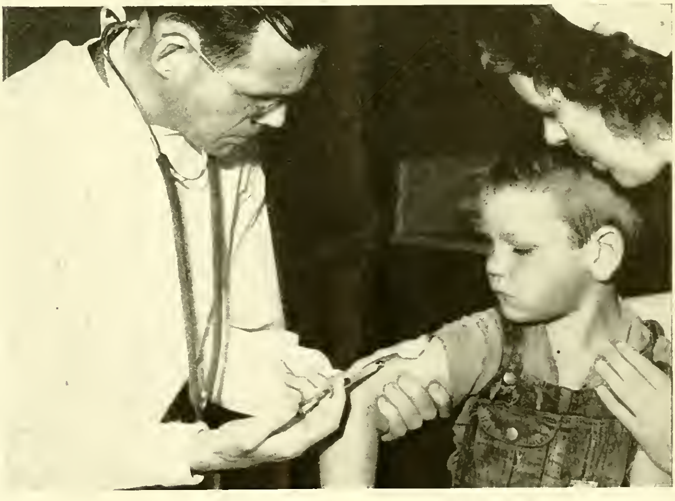
The people in the towns that depend on these workers for the extra hands they need to get out the crops may say: "They are here only 6 weeks; it doesn't matter." But to the migratory families themselves the problem of how to feed, clothe, and shelter the children so as to keep them from getting sick is a perpetual one even though the locality changes.

In recent years some migratory farm families have benefited from special public-health projects planned and carried out with the purpose of supplying health services to these families. The families that these projects are planned for are as a rule not residents of the State or county they are living in at the time they need such services.

A large-scale effort to give medical care to migratory farm families, started by the Farm Security Administration in 1937, is now administered by the Health Services Branch, Office of Labor, United States Department of Agriculture. As a means of utilizing fully the services of local doctors and other health resources in serving the health needs of migratory farm families six corporations called agricultural workers' health associations were formed. These nonprofit corporations extend their services through-

THE DOCTOR AT A FARM-LABOR SUPPLY Center for migratory workers is giving Billy an injection to immunize him against tetanus and diphtheria.

Photograph by Office of War Information



out the country. They engage the services of physicians and dentists, buy drugs and equipment, negotiate with hospitals for care, employ nurses and clerical personnel, and carry on other activities to provide health services without cost to farm workers. This work is described in *Public Health Reports,* March 2, 1945 (Vol. 60, No. 9).

During the last few years, all farm workers and their families that live in farm-labor supply camps or centers (in certain instances, those living in the areas surrounding these centers) have been eligible to the health services which these associations provide.

Probably more than 150,000 persons a year—among them many children of migratory farm families—receive health services through this program. Of these 150,000 persons all but about 40,000 are foreign workers without families. It is only with the services to the children in the domestic migratory families that this article is concerned. Much of the information was obtained from Dr. Henry B. Makover, Senior Surgeon (Reserve), United States Public Health Service, assigned as Chief, Health Services Branch, Office of Labor, United States Department of Agriculture.

The most extensive health services reaching these children are given in the farm-labor camps or centers. Each of these farm-labor centers has a clinic with a registered nurse in charge, which is served by a panel of local physicians and dentists, who attend 2 or more days a week on a rotating basis. These clinics provide a continuous program of preventive services and medical care. During 1945 farm workers' families in 58 farm-labor camps or centers in 12 States received such services. Among the 58 camps were 22 mobile camps with mobile clinics.

To prevent spread of disease

All children entering farm-labor camps are given a general physical examination and if necessary are immunized against smallpox, diphtheria, and whooping cough. Immunization against other diseases—for example tetanus—is given according to the needs of the child and of the region.

Photograph by Office of War Information

A PUBLIC-HEALTH NURSE is showing Juanita, a child in a family of farm migrants, how to attend to her scratched knee, and is supervising her carefully. The nurse is impressing on Juanita importance of caring for even minor injuries.

Children living in the camps are given health education; health supervision in nursery schools; dental services, which include preventive care; and surgery.

3,000 given care in 3 months

Information is not available as to the number of children under 15 years of age in farm-labor camps but it is known that during the first 3 months of 1945 nearly 3,000 children of this age group living in such camps received medical care under this program. Eighty-three of these children were given hospital care for a total of 550 hospital days.

The number of immunizations given was 2,886; of these 2,112 were for smallpox, 547 for diphtheria, and 227 for whooping cough.

A total number of 311 children received dental care. The dental services included nearly 800 fillings, more than 200 treatments, 134 extractions, and other services.

Some of the more important illnesses for which children were treated were: Infectious and parasitic diseases, almost 200 cases; malnutrition, 10; skin diseases, 217; injuries and poisonings, 178; diseases of the respiratory system, 714; and diseases of the digestive system, 218. Six children were treated for acute rheumatic fever and 4 for chronic rheumatic heart disease.

A more limited type of health service consisted of examinations given in recruitment areas to a few migratory farm families who were at that time transported by the War Food Administration. The purpose of this service was to help prevent the spread of communicable diseases and to find out whether the applicants would be able to do the work after their transportation had been provided. An effort was also made to give smallpox vaccinations to those who were accepted.

Another important service is the placing of nurses on many trainloads of workers to care for persons with minor illnesses and to give first aid, to arrange for the services of a doctor or for hospital care in cases of serious illness, and to give simple instructions in personal hygiene.

Records sent to next camp

One of the important features of this Federal program has been the referral of a person's complete medical records to the public-health officers in the next place he is going, hen his destination is known. A ard indicating the kind ot immuizations a child has had is given to e parent to carry with him. This eferral system forms a basis for ontinuous treatment as the migrant amily follows the crops.

tate programs under way

In addition to this Federal public-ealth program, which came about ecause of the special needs of ecoomically depressed families that ove with the crops and are usually ot residents of the State or county here they are working, other eforts to improve the health of mirants may be in the offing. Recently ome States, realizing that they are lependent on the labor of migratory arm families, are taking new interst in extending public-health serices to them.

For example, in New Jersey a w passed in 1945 establishes a mirant-labor division in the State department of labor. This division has responsibility for cooperating with the State health department in seeing that health services are available to migrant families. At present a survey is being made to find out what kinds of health services are needed in preparation for carrying out the purposes of the new act.

New Jersey also has a law providing that all agricultural migrants who have not been examined for venereal diseases within 90 days before their entrance into the State must have such an examination and if infected must be treated.

Another example of State planning to provide health services is found in New York where State agencies and committees have been cooperating in finding out about the living and working conditions of migratory families and in acting to improve such conditions. During 1945 the State health department has been providing increased facilities for maternal and child health and for the diagnosis and treatment of tuberculosis and of venereal diseases for families in migratory farm camps. Recently public-health nurses have been locally assigned to visit farm-labor camps regularly, to search for evidence of communicable disease, to check on the general health of the families, and to report any condition that requires the attention of a physician to the local or district health officer. Patients unable to pay for needed medical care are referred to the local welfare authorities.

The local welfare officials certify to the need for medical care, and the State welfare department reimburses the local department for such expenditures.

In general, progress has been made in providing health services to migratory farm families. But under present legislation provision is made to operate Federal farm-labor supply centers or camps and to carry on health services for farm workers only until December 31, 1945. What of the health of the migratory families then? Only a few States have developed machinery to provide health services to agricultural migrants. Moreover, the problem of the migratory farm family is of National as well as State importance and many aspects of it require planning and action by the Nation.

What can we do?

In order to understand the problem and to solve it, the people who live in areas that depend on migratory agricultural labor might well (1) visit the migrants to examine and become familiar with the kind of health service available to these families and with their health needs, (2) tell others about the conditions they find and the conclusions they have reached, and (3) work with other local, State, and National groups in making plans, taking action, and passing legislation to provide health services that not only will benefit the migrants but will also help to raise the health level of the whole community.

(This is the first of a series of articles on children in migratory farm families.)

> **The existence of a class of migrants is a concern to every element of this society of ours of which it is a part. Public stability and the health of our public life require:**
>
> **That it be reduced to a reasonable volume;**
>
> **That those who engage in it shall receive the protections and opportunities which society is accustomed to accord to its other workers; and**
>
> **That they shall not be isolated from the communities which they serve, by aloof or hostile attitudes of residents who may falsely assume that only they are "the community."**
>
> **Employers, organized laborers, and people of civic spirit are coming to recognize as a principle of sound economy and politics—not simply as a dictate of humanity—that no person who by choice or force of circumstances moves from place to place in order to gain livelihood should lose his human rights as a consequence of migration.**
>
> **PAUL S. TAYLOR,** *Professor of Economics, University of California, at Institute of Migratory Labor Problems, Princeton, N. J., June 26, 1945.*

A limited supply of reprints of this article will be available from the Children's Bureau, Washington, D. C.

TO IMPROVE HEALTH OF SCHOOL CHILDREN

Report Urges Community Health and Education Departments to Coordinate Health Programs for Children of School Age

All the children in a community will benefit from its public-health activities only when its departments of health and education work together so that the health program of the schools is coordinated with that of the community as a whole. This is one of the conclusions of a subcommittee representing 12 national agencies that sponsor or administer programs affecting the health of school children. This subcommittee has just finished a preliminary investigation to find out what school children need in order to have better health and has prepared a report pointing out these needs and suggesting how they can be fulfilled through strengthening and supplementing the present programs.

Study school health needs

The subcommittee was appointed in January 1945 at a meeting held for the purpose of exchanging information concerning the health of school children, studying the needs of such children, and making recommendations for future action. This meeting, which was called at Washington by Frank S. Stafford, Chief, Health and Physical Education, United States Office of Education, included representatives of the following agencies:

Federal Security Agency:
  United States Public Health Service.
  Committee on Physical Fitness.
  United States Office of Education.
United States Department of Labor, Children's Bureau.
United States Department of Agriculture:
  War Food Distribution.
  Extension Division.
Office of Community War Services, Recreation Division.
American Red Cross.
Office of the Coordinator of Inter-American Affairs.
American Association for Health, Physical Education, and Recreation, National Education Association.
American Public Health Association, School Health Section.
National Organization for Public Health Nursing.

Children of school age, according to the subcommittee, need (1) to have a safe, sanitary, and healthful school environment; (2) to be protected from infections and other conditions that interfere with proper growth and development; (3) to receive adequate medical and dental care, to be well nourished to develop physically, to have wholesome recreation, and to achieve balance and rhythm; (4) to learn how to live healthfully; and (5) to be educated by teachers who are equipped through training, temperament, and health not only (a) to give specific instruction but also (b) to help the children to develop healthful personalities.

That the health needs of school children are not being met is shown by the subcommittee through data from many parts of the United States.

The report points to the fact that in 18 States more than half the school buildings in use are one-teacher schools, adding that this does not mean that one-teacher schools contribute to ill health but that the existence of these schools indicates the need for buildings that can serve all the needs of the whole community.

Selective-service figures are also cited in connection with a study in Hagerstown, Md., to show that large numbers of children had grown to manhood with remediable defects that had been discovered in their school days but that had not been corrected. Referring to the need for immunizations and other preventive measures, the report states that little or no medical service is available to school children in rural areas, where about 50 percent of the Nation's school children live. Public-health nurses provide service, but this is insufficient; in fact, in more than a quarter of the counties there is no public-health-nursing

IT'S LUNCH TIME AT SCHOOL. Joe and Ann are enjoying what nutritionists call a type-A lunch, providing one-third to one-half of the day's food needs.

Photograph by U. S. Department of Agriculture

service, according to the report.

In connection with the need for teachers who can understand the needs of children and help to fulfill them the report quotes from bulletins of the Office of Education, pointing out deficiencies in the average school administrator and classroom teacher and suggesting lines along which efforts might be made to improve the personnel.

Complex program needed

To meet such needs as these effectively will require a complex program, the report states. The complexity results in part from the fact that the school-age child is subject to the concern and influence of numerous agencies, professional groups, and individuals who are interested, officially or unofficially, in programs that affect the health of the community in general and frequently the health of the child in particular.

The two official agencies most likely to sponsor health programs for children are the health and education departments. That the responsibilities of these two agencies are joint and overlapping, the subcommittee suggests, can be shown by filling out a check list of essentials for a school health program. Such a check list is included in the report, with spaces in which the agency carrying the responsibility for each item may be indicated.

Recommendations for action by State and local authorities include the following:

1. Committees comparable to the coordinating committee on the Federal level should be established at the State and local levels between departments of public education and health. These committees may include representatives from professional educational institutions and other agencies and professional groups concerned with the health of the school child.

2. In the department responsible for health instruction, physical education, and health services there should be qualified professional personnel such as physicians, nurses, and educators, all of whom have been trained in school health.

3. A comprehensive program to meet the health needs of school children in any State should provide for:

a. Development or extension of programs in teacher-education institutions to prepare administrators and teachers so that they can participate effectively in the school health program.

b. Appropriate pre-service and in-service education for school-health administrators, teachers, nurses, physicians, dentists, nutritionists, and other specialized health personnel serving the schools.

c. Adequate time allotment for health instruction and physical education of children and for their participation in solving individual and community health problems.

d. Planning for construction and inspection of the school plant and its sanitary provisions and a planned program to insure and utilize a safe and sanitary school environment, including transportation.

e. Thorough school medical examinations including necessary immunization and laboratory procedures.

f. Special testing programs and treatment as needed for abnormalities such as those of vision, hearing, and speech.

g. Cumulative health records including record of nutritional status.

h. A school-lunch program developed as part of the total educational program.

i. Dental care.

j. Mental hygiene.

k. Care for children with crippling diseases, especially rheumatic fever.

l. Treatment as needed for other adverse health conditions.

m. Demonstration areas for the development of improved techniques to meet the needs with respect to the school health programs of the individual States.

n. Organized program of parent participation and education.

o. Health services for school personnel.

Coordinating committee

Turning its attention to activities of the Federal Government with regard to school health programs, the subcommittee, in recognition of the need for cooperative planning among the various Federal agencies, recommended appointment of an official coordinating committee.

This committee, with the title of "The Inter-Agency Committee on Health Programs for School-Age Children," has since been appointed by the Chief of the Children's Bureau, the Surgeon General, and the Commissioner of Education.

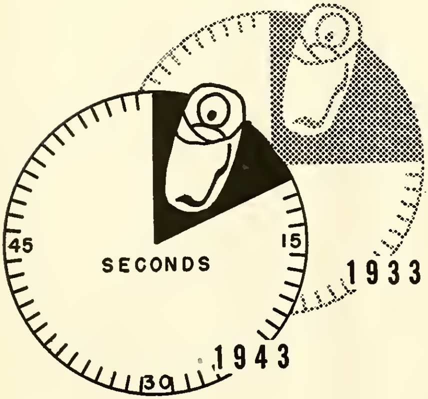
The members are: Dr. Katharine Bain, Director of Division of Research in Child Development, Children's Bureau; Dr. Mayhew Derryberry, Chief of Field Activities and Health Education, U. S. Public Health Service; and Frank S. Stafford, Chief, Health and Physical Education, U. S. Office of Education.

This committee will take part in coordinating existing programs, in planning any extension of these programs, in the formulating of over-all policies, and in the setting up of regulations governing the administration of any funds that may be made available.

BOBBY, IN HIS FIRST YEAR AT SCHOOL, is being treated by the school dentist. If he receives care every year he will never have serious teeth problems.

Photograph by Office of War Information

TEN-YEAR MATERNAL AND INFANT-MORTALITY RECORD POINTS



A baby was born every 15 seconds in 1933, the year when the Nation was trying to pull itself out of its worst economic depression.

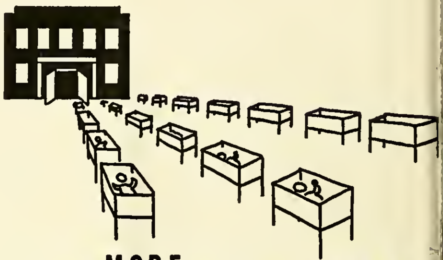
A baby was born every 11 seconds in 1943, the year when the Nation was at a peak of war activity.

Two million babies were born in 1933; three million in 1943. The birth rate rose from 16.6 births per 1,000 population in 1933 to 21.5 births per 1,000 population in 1943.

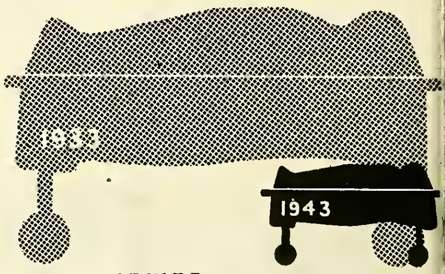
The facts shown on these pages are based on Census data for 1943, the latest available. When later figures come out they will undoubtedly show that the problems facing us in saving mothers' and babies' lives will not be materially different.

A detailed account of 1933-43 progress in reducing maternal and infant mortality will appear in an early issue of *The Child.*

PROGRESS 1933-43



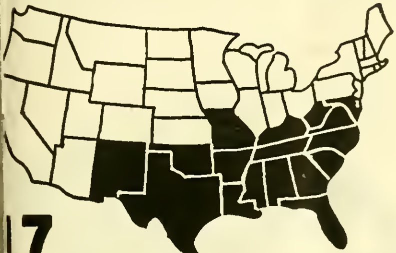
IN 1943 **MORE** BABIES WERE BORN IN HOSPITALS THAN IN 1933
(INCREASE 106%)



IN 1943 **FEWER** MOTHERS DIED FROM CHILDBEARING THAN IN 1933
(MATERNAL MORTALITY RATE DOWN 60%)

UNFINISHED BUSINESS IN SAVING MOTHERS' AND BABIES' LIVES

BUT EVEN IN 1943



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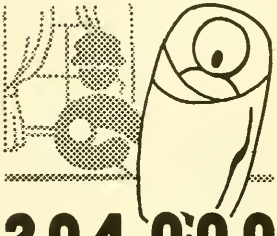
TATES WERE BELOW THE NATIONAL VERAGE IN HOSPITAL BIRTHS (NATIONAL AVERAGE 72%)

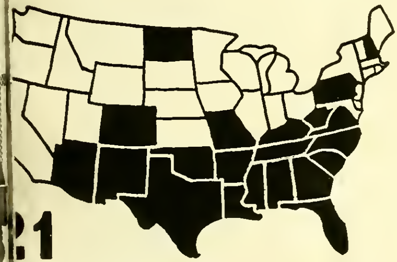
819,000

BABIES WERE NOT BORN IN HOSPITALS



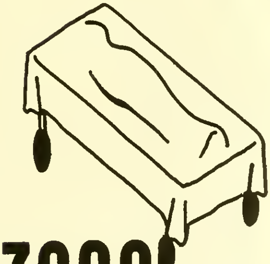
204,000

BABIES WERE BORN WITHOUT A DOCTOR



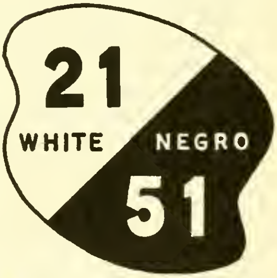
21

ATES WERE LESS SUCCESSFUL IAN THE NATION AS A WHOLE SAVING MOTHERS' LIVES (RATE FOR NATION: 25 MATERNAL DEATHS PER 10,000 LIVE BIRTHS)



7,000 MOTHERS DIED FROM CHILDBEARING

➜ WHITE 5,000
➜ NEGRO 2,000



RISKS OF CHILDBEARING WERE TWICE AS GREAT FOR NEGRO MOTHERS AS FOR WHITE MOTHERS

4,500 MOTHERS DIED FROM THE TWO CAUSES, INFECTION AND TOXEMIA
MOST OF THESE DEATHS COULD AND SHOULD HAVE BEEN PREVENTED

(*Continued on page* 58)

TEN-YEAR MATERNAL AND INFANT-MORTALITY RECORD POINTS T

FIVE TIMES as many babies died in 1943 as there were U. S. servicemen killed in action in that year of world-wide war. Our loss of men on the battle front was 24,000. Our loss of babies (in their first year) on the home front was 118,000.

1943's record showed a gain over 1933, when 121,000 babies died. But we have far to go before we can claim that every infant death is unavoidable, unpreventable.

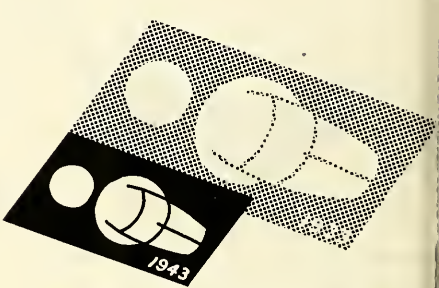
Adequate nursing and medical care would have saved many of the babies who died in 1943 from prenatal and natal causes, responsible for the death of 71,000.

Adequate medical and nursing care would have saved all, or practically all, of the babies who died in 1943 from such infectious diseases as these: Influenza and pneumonia, which killed 18,000; dysentery, diarrhea, and enteritis, which killed 10,000; epidemic and other communicable diseases, which killed 4,000.

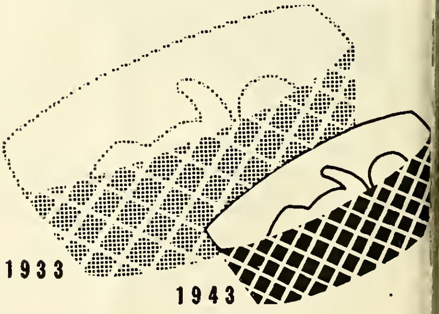
Records of progress in the past count for little unless they are used to draft plans for progress in the future.

As the charts on these pages show, the route to progress ahead lies in getting more and better care for babies in the States that have been less successful in saving babies' lives than the Nation as a whole (and in handicapped areas even in States that have a better record than the national average); in doing a better job of caring for mothers during pregnancy and at childbirth.

PROGRESS 1933-43-



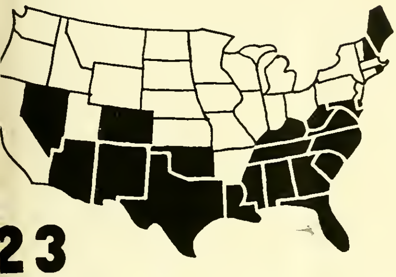
IN 1943, THOUGH MANY MORE BABIE
WERE BORN, **FEWER** BABIES DIED I
THEIR FIRST YEAR THAN IN 193
(MORTALITY RATE, FIRST YEAR OF LIFE, DOWN 31%



IN 1943 A BABY'S FIRST DAY OF LIF
WAS **LESS** DANGEROUS THAN IN 193
(MORTALITY RATE, FIRST DAY OF LIFE, DOWN 23

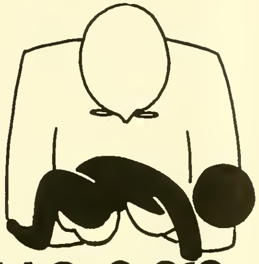
NFINISHED BUSINESS IN SAVING MOTHERS' AND BABIES' LIVES

BUT EVEN IN 1943



23

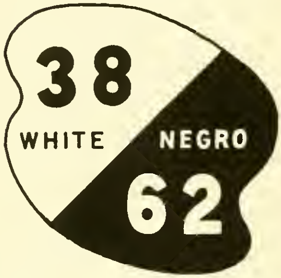
TATES WERE LESS SUCCESSFUL
HAN THE NATION AS A WHOLE
N SAVING BABIES' LIVES
(RATE FOR NATION: 40 INFANT DEATHS PER 1,000 LIVE BIRTHS)



118,000

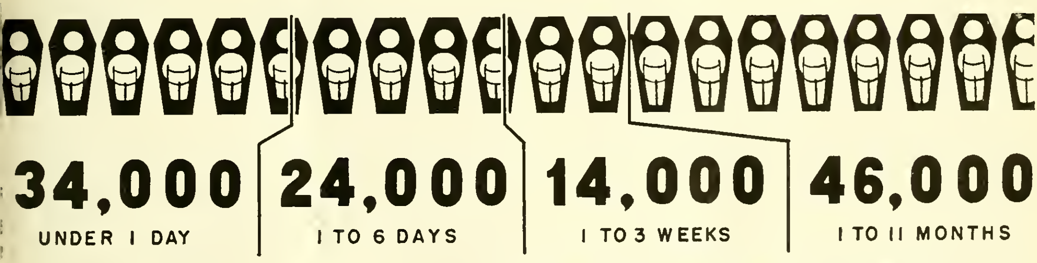
BABIES DIED IN THEIR FIRST YEAR

➜ WHITE	97,000
➜ NEGRO	20,000
➜ OTHER	1,000



RISKS OF DEATH FOR NEGRO BABIES WERE MUCH GREATER THAN FOR WHITE BABIES

29 PERCENT OF ALL THE BABIES THAT DIED IN THEIR
IRST YEAR OF LIFE DIED BEFORE THEY WERE A DAY OLD



34,000	24,000	14,000	46,000
UNDER 1 DAY	1 TO 6 DAYS	1 TO 3 WEEKS	1 TO 11 MONTHS

For reprints write to U. S. Children's Bureau, Washington 25, D. C.

STATES IMPROVE CHILD-LABOR STANDARDS

1945 Legislatures Enact Better Child-Labor and Compulsory-School-Attendance Measures

by NORENE McDERMOTT
Industrial Division, U. S. Children's Bureau

During the early months of 1945, when most of the State legislatures that met this year were in session, the Nation was still at war and the prospect of peace was far away. In spite of this, pressure to break down child-labor standards decreased noticeably and a pronounced change for the better took place in the trend of State child-labor legislation.

For the first time since Pearl Harbor the backward steps in legislation were fewer and less significant than the advances. Many outstanding improvements were made in State child-labor laws, as well as in workmen's compensation laws as they affect illegally employed minors. The trend toward better compulsory-school-attendance laws, which was evident even in the prior war years, has continued.

This upsurge of interest in improving legislative measures may be attributed to various factors, such as the growing realization among the public of the lacks in the present laws and definite efforts on the part of organizations and individuals to obtain improvements in such laws.

The unprecedented demand for young workers during wartime had pointed up as never before the gaps in coverage and other inadequacies of State child-labor laws. As a result, individuals as well as organizations began to recognize the urgent need for strengthening both child-labor and compulsory-school-attendance legislation. Moreover, wartime peaks in employment were subsiding in some communities. This lessened to some extent the demand for young workers and offered an opportunity for beginning a drive for better standards.

Just before the 1945 legislative sessions, the Children's Bureau initiated a drive to encourage the States to establish a 16-year minimum age for employment in any manufacturing or mechanical establishment at any time and in any gainful occupation during school hours. Improvement of other child-labor standards was also urged. This drive served to emphasize the lack of child-labor protection and no doubt encouraged and helped State movements for the improvement of child-labor legislation.

The National Child Labor Committee gave stimulus and help to the movement.

The A. F. of L. and the C. I. O. at their annual conventions adopted resolutions uring States to set a 16-year minimum age for employment.

The Eleventh National Conference on Labor Legislation in December 1944 went on record in favor of immediate action to establish under State laws a 16-year minimum age for employment at any time in "manufacturing, mechanical, and processing occupations," and in all other occupations a 16-year minimum age for work during school hours and a 14-year minimum for work outside school hours and during vacations.

I.A.G.L.O. favors standard

State labor commissioners, through their organization, the International Association of Governmental Labor Officials, have for years urged a similar standard.

During 1945 the legislatures of 44 States, Alaska, Hawaii, and Puerto Rico met in regular session; those of 2 others, Kentucky and Virginia, met in special session. Louisiana and Mississippi were the only States in which the legislatures did not meet.

In more than half the legislatures bills were introduced to improve legislation affecting young workers. Many of these bills were successful. Child-labor laws were improved in 7 States—Illinois, Maine, New York, Connecticut, Rhode Island, California, and Nebraska—and Hawaii, as were compulsory-school-attendance laws in 5 States—Georgia, North Carolina, Oregon, Texas, and West Virginia. Improvements in the status of illegally employed minors under workmen's compensation acts were made in New Jersey, Iowa, and Minnesota.

In one other State, Georgia, a new child-labor law was adopted by one house before the legislature recessed and is to be considered in the other house in January, 1946, when the legislature reconvenes.

Child-labor committee formed

In addition, the Michigan legislature, although it failed to enact a revised child-labor law, created a committee to study the problems of child labor and to recommend legislation for correction of any abuses found.

The important industrial State of Illinois passed a new child-labor act, to be effective 6 months after the end of the war has been declared.

The most significant improvement that will be brought about by the new act in Illinois is the adoption of a higher minimum-age standard. In establishments that now have a 14-year minimum for work at any time and in several additional types of establishments, the law sets a 16-year minimum for work during school hours and a 14-year minimum for work outside school hours.

The employment-certificate provision has been strengthened by the new Illinois act. This act includes a requirement that children under 16 years of age be allowed 30 minutes for meal periods. The work of school children under 16 employed outside school hours will be limited to 3 hours a day. The present provision limiting combined hours of school and work to 8 a day is retained. Employment of children in farm labor is specifically exempted from the provisions of the law. Special provisions are included for child actors appearing in plays or musical comedies with professional traveling theatrical companies.

Although the revision of the law has in general strengthened it, in some respects certain provisions have been weakened. For example, the provisions restricting maximum hours of work and night work will be applicable only to specific establishments instead of to all gainful occupations as at present.

Maine raises minimum age

Maine strengthened its child-labor law in several particulars. It raised from 14 to 15 the minimum age for employment in any manufacturing or mechanical establishment, bowling alley, or poolroom, and also established a 15-year minimum age for work in laundries and bakeries. It raised from 14 to 15 the age at which a child of subnormal mental capacity may obtain a work permit.

Maine also established a minimum age of 18 for any work that the Commissioner of Labor and Industry determines to be hazardous in manufacturing or mechanical establishments, laundries, or bakeries. The maximum 54-hour week for children under 16 and for women in specified establishments was extended to apply to hotels.

Improvements in provisions relating to hours of work of minors were also made in New York, Connecticut, Rhode Island, and Hawaii.

Wartime employment of school children has demonstrated anew the need for controlling hours of work of in-school youth. One-fourth of the States introduced bills to regulate such work. In addition to Illinois, which as already noted included in its new act a limitation on hours of work of in-school youth, one other State, New York, enacted such legislation, effective January 1, 1946, applying to the hours of work of youth under 17 years of age. New York is the second State to control hours of part-time work for students after they reach 16 years of age. California has limited, for many years, the combined hours of school and work of both 16- and 17-year-old minors as well as those under 16. In the New York act, the hours of work of in-school youth under 16 are limited to 3 a day on school days and 23 a week in school weeks; the hours of such young persons who are 16 years old are limited to 4 a day on school days and 28 a week during school weeks. Farm labor is exempted from the act for both age groups, and the sale and distribution of newspapers is exempted for minors of 16.

Connecticut reduced from 52 to 48 the maximum weekly hours which any minor under 16, or any female, may work in restaurants, cafes, barber shops, and a few other types of establishments. This act is to become effective 6 months after the rescinding of the Federal employment-stabilization regulations. (These were rescinded August 17, 1945.)

Rhode Island limited, for the first time, the night work of minors 16 and 17 years of age. In an act to become effective January 1, 1946, it prohibited the work of such minors between 11 p.m. and 6 a.m. in any factory, manufacturing, or mechanical establishment. Hawaii limited the employment of children between the ages of 12 and 14 to 30 hours a week and 6 hours a day, except in domestic service, street trades, and work for their parents.

Children employed on farms

A significant development this year is the enactment of legislation in Hawaii and New Jersey that will benefit children employed in agriculture. In New York, the 1944 act requiring farm work permits for employment of minors 14 and 15 years of age in farm service, which would have expired July 1, 1945, was continued for one more year.

Hawaii clarified the provision of its law which sets a minimum age for employment of children in agriculture at times when the child is not legally required to attend school, definitely setting this age at 12 years. At the same time it brought all children under 16 engaged in such work within the coverage of the employment-certificate provisions of the child-labor law, as well as of those regulating hours, night work, and meal periods. Hawaii also extended the coverage of its wage-and-hour law so as to apply to any employee working in agriculture during any workweek in which his employer employs 20 or more persons, as well as to employees working in certain other occupations. The minimum hourly wage rate is raised by the new act from 30 cents (25 cents in certain counties) to 40 cents. This act, however, provides specifically that a lower rate may be set for children 14 years of age and under, by regulation of the department of labor and industrial relations of the Territory of Hawaii.

15-YEAR-OLD Walter works in a grocery store 2 hours a day after school 5 days a week—Monday to Friday—and 8 hours on Saturdays. These working hours are legal for a schoolboy of his age under the child-labor laws of his home State.

Photograph by Office of War Information

Of far-reaching significance is the New Jersey act that creates within its department of labor a division of migrant labor. One of the duties of the division is to enforce the child-labor law with respect to children in migrant-labor camps.

Two States, California and Nebraska, improved the administrative provisions of their child-labor laws. California inserted a penalty for violation of the provisions relating to employment of children in public performances. Nebraska authorized the State department of labor to prescribe forms for age and schooling certificates, repealing the provision of the law specifying certain forms which had become obsolete.

Laws strengthening school-attendance requirements are a strong support to minimum-age standards.

Better school-attendance laws

Georgia and North Carolina were the only States having less than a 16-year upper age for compulsory school attendance at the beginning of this year. Both were successful in adopting new compulsory-school-attendance laws. The Georgia law requires attendance of children between 7 and 16 years of age instead of between 8 and 14 as formerly. The minimum period of annual school attendance required is lengthened from 120 to 175 days or to the full term that school is in session. Enforcement provisions are also strengthened by the new act. The North Carolina law sets the upper age for compulsory attendance at 15—to be raised to 16 on July 1, 1946. Both laws permit some exemptions.

Oregon lowered the beginning age for required school attendance from 8 years to 7. Both Oregon and Texas narrowed the exemptions under which children under 16 are excused from required school attendance, and West Virginia strengthened the provision of its law authorizing free transportation for certain school children.

In 3 States important amendments were made to workmen's compensation laws. In Iowa and Minnesota illegally employed minors were brought within coverage of such laws. New Jersey raised from 16 to 18 the age under which double compensation is paid in case of injury to minors employed without a certificate or employed in a prohibited occupation.

Some backward steps taken

The most serious backward step in child-labor legislation was taken in Hawaii, which, while adopting the improvements previously described, lowered from 16 to 12 the minimum age for factory work during periods when the child is not required to attend school. The 16-year minimum age is retained, however, for such work during periods when the child is required to attend school.

Other regressive acts include amendments to hazardous-occupations laws of Maryland, Massachusetts, and Utah.

Five States—California, Indiana, New York, Ohio, and Utah—extended for 1 or 2 years, or until the end of the war, relaxations that were scheduled to expire in 1945.

At the same time, however, a tightening up of relaxations began. California extended its Minors' Emergency War Employment Act, but at the same time provided that the department that recommends the issuance of a permit may also recommend its revocation when it finds that the permit is no longer necessary to increase production. Even more indicative of the tightening up is the fact that Indiana did not extend an emergency act authorizing release of children from school for work in agriculture.

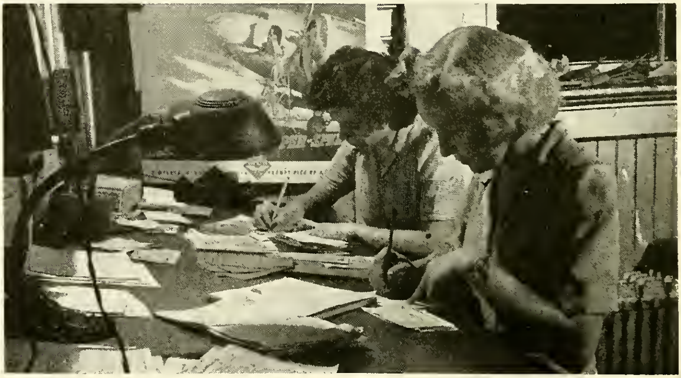
In this connection it is of interest that the Secretary of Labor ordered, effective September 4, 1945, the withdrawal of the 1942 exemption from the 18-year minimum age for girls employed under the Walsh-Healey Act. That exemption permitted girls of 16 and 17 to be employed under certain conditions.

Review of results

A review of the results of the 1945 legislative year shows that considerable progress has been made, particularly in view of the fact that we were still at war when the legislatures were in session. Although some acts lowering standards were passed this year and the advances made were not as far-reaching as could be desired, still the gains outweigh the losses, and the way is paved for greater improvements in employment protection for children and young people in the years ahead.

THE FIRM EMPLOYING these 16-year-old girls did not hire them until it had obtained age certificates for them from the local school authorities. The firm knows, therefore, that it is not breaking the child-labor law of the State by employing children under 16 years during the hours when school is in session.

Photograph by Office of War Information



Note: Further information on any act mentioned in this article can be obtained from the Children's Bureau on request. A limited supply of reprints of this article will be available from the Children's Bureau, Washington 25, D. C.

MEXICO REORGANIZES ITS CHILDREN'S AGENCY

by ANNA KALET SMITH
Office of the Chief, U. S. Children's Bureau

Mexico's new Bureau of Child Health and Welfare has responsibility for the health and welfare services for mothers and children provided by the Federal Government. This Bureau (Dirección General de Higiene y Asistencia Infantiles), which is a unit of the Federal Department of Health and Welfare (Secretaría de Salubridad y Asistencia), replaces the former Bureau of Child Welfare as a result of a reorganization of the health and welfare work in the Federal Government, which took place in the fiscal year 1943-44. The new Bureau not only directs services in the Federal District, as was done by the former Bureau, but also those in the States and Territories. In general the activities of the present Bureau are more extensive than those of its predecessor.

The Bureau of Child Health and Welfare consists of a Division of Medical and Social Care (Departamento de Asistencia Médico-Social) and a Division of Social Welfare for Mothers and Children (Departamento de Acción Social, Infantil y Maternal).

Division of Medical and Social Care

The Division of Medical and Social Care has charge of the Bureau's health centers for mothers and children. Seventeen such centers were located in the Federal District alone in 1944. Public-health nurses on the staff of these centers call on mothers at home to urge them to come to these centers. They teach the mothers how to care for their own health and their children's and how to prepare food for the family. These nurses also carry out treatment prescribed by physicians.

Medical care, consisting of physical examinations and treatment in illness, is provided by the Bureau to children in day-care centers, in foster homes, and in institutions for dependent and delinquent children. For the purpose of medical supervision Mexico City is divided into 14 zones, each in charge of a physician, who is assisted by other physicians—an ophthalmologist, an ear, nose, and throat specialist, and a dermatologist — and by a dentist. The children are examined twice a year. Treatment is given for illnesses or defects, and in cases of emergency.

Mental-hygiene clinic established

In 1944 the Bureau established a mental-hygiene clinic in an effort to prevent mental ill health among children and to rehabilitate problem children.

The Bureau's Division of Social Welfare for Mothers and Children considers social case work with individuals as one of its most important functions. It recognizes the importance of family life for the child, and it follows the principle that poverty of itself should never be a cause for removing a child from his home.

Social workers on the staff of the Division investigate the cases of children in day-care centers, foster homes, and institutions. In some institutions it has been possible to investigate the case of every child, and children whose stay at the institution was found to be unwarranted have been returned to their families. Many children benefited through economic aid given to the family by the Bureau or by one of the committees of volunteers cooperating with the Bureau. This Division also investigates persons who wish to adopt children.

Another activity of the Division during 1943-44 was the supervision of school lunches in 34 places in the Federal District.

The Division of Social Welfare for Mothers and Children also directs the work of 26 mothers' clubs in the Federal District.

The Division of Social Welfare is responsible for the supervision of children cared for in foster families in Mexico City. The number of such children was about 450 in 1944. The board for these children was paid by the Bureau of Child Health and Welfare.

The committees of volunteers mentioned previously play an important part in the Bureau's work. During the year these committees collected funds with which they established several day-care centers, maintained a children's clinic and a school-lunch program, and purchased clothing and toys for distribution among children. These committees also gave financial help to the mothers' clubs.

Other work reported by the Bureau for its first fiscal year includes publication of material for use by physicians and others engaged in work for mothers and children; issuance of regulations for subordinate agencies; preparation of a book on child hygiene for the use of rural teachers; and compilation for publication of the proceedings of the First National Congress of Social Welfare, held at Mexico City in 1943.

Through an agreement with the Rockefeller Institute of New York, the Bureau with the aid of the Institute will convert one of its health centers for mothers and children into a training center for physicians and other workers in the maternal and child-health field.

During the fiscal year 1943-44, the Bureau also made a study of measures for improvement of the legal and social status of neglected and dependent children.

Source:
Secretaría de Salubridad y Asistencia Memoria, 1943-1944, *México*, 1945.

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The American Social Hygiene Association has established a committee on Inter-American Cooperation as a section of the Association's general advisory committee, according to an announcement by Dr. Thomas Parran, Surgeon General, United States Public Health Service, who is chairman of the general advisory committee.

●

Msgr. John A. Ryan
1869-1945

A brave campaigner in the struggle for human betterment was lost to the Nation and to the world when the Rt. Rev. Msgr. John A. Ryan died September 16.

Throughout his life Msgr. Ryan crusaded for social reform through forward-looking legislation. In 1909 he published a comprehensive program for such reform. Some of the items included were setting of a minimum wage, an 8-hour maximum working day, a minimum age of 16 for employment of children, creation of boards to provide for conciliation and arbitration in labor disputes, State employment agencies, municipal housing, and State insurance to meet unemployment, accidents, sickness, and old age.

In 1911, when no State in the Union as yet had a minimum-wage law, Msgr. Ryan wrote a bill providing for a minimum wage for women and children, which was introduced in the Minnesota legislature. It failed of enactment, but 2 years later another bill written by Msgr. Ryan passed, and by that time his efforts had set an example that was being followed by a number of States.

During the first World War Msgr. Ryan drew up a program for social reconstruction. This program was promulgated in 1919 by the National Catholic War Council, which was the predecessor of the National Catholic Welfare Council. To achieve the goals of this program, which was known as the "Bishops' program," the Council established its social-action department, of which Msgr. Ryan was director from 1920 until his death.

Msgr. Ryan was an ardent worker for the proposed child-labor amendment, urging ratification in a pamphlet published by the National Child Labor Committee and in many other public statements.

The Government often called upon Msgr. Ryan for advice on social and labor problems. He was a member of the advisory council to the Committee on Economic Security, which planned the Social Security Act.

Msgr. Ryan's courageous spirit and penetrating insight into the economic foundations of social institutions, particularly the family, and his constant advocacy of measures that would promote high standards of living and safeguard children and youth place him in the front rank of social statesmen.

First Inter-American Congress on Social Service

"Social Service for the Protection of Children and Adolescents" was the subject of a paper by Katharine F. Lenroot, Chief of the Children's Bureau, presented at the First Inter-American Congress of Social Service, at Santiago, Chile, September 9 to 15, 1945. In Miss Lenroot's absence, the paper was read by Mrs. Elisabeth Shirley Enochs, Director of the Inter-American Cooperation Unit of the Children's Bureau and chairman of the United States delegation to the Congress.

The other members of the United States delegation were: Mary Cannon, Director, Inter-American Division, Women's Bureau, Department of Labor; Jane M. Hoey, Director, Bureau of Public Assistance, Social Security Board, Federal Security Agency; the Rev. Lucian Lauerman, Director, National Catholic School of Social Service, Washington D. C.; Walter W. Pettit, Ph. D., Director, New York School of Social Work, New York; and Mrs. María Pintado de Rahn, Director, Department of Social Work, University of Puerto Rico, Rio Piedras, Puerto Rico.

I. L. O. Meets at Paris

Welfare of children and young workers is a major item on the agenda of the twenty-seventh session of the International Labor Conference, which opens in Paris, October 15. This subject, which has been conidered by the Conference in various aspects at a number of its sessions since 1919, appears on the 1945 agenda with special significance owing to the effects of the war on children in many countries. These effects, in the words of a report of the International Labor Office, "have greatly aggravated the social problems affecting children and young workers and have seriously endangered the future of the younger generation."

Katharine F. Lenroot, Chief of the Children's Bureau, is attending the Conference as a member of the United States Government delegation. She will participate in the Conference discussions concerning children and young people.

Miss Lenroot was one of the 15 experts from various countries who met in Montreal last May at the invitation of the International Labor Office to advise the Office on matters that should be included in the material prepared by the Office for consideration at the Conference in regard to the welfare of children and youth.

The United States Government delegates are Frances Perkins, former Secretary of Labor, and Elbert D. Thomas, United States Senator from Utah. Miss Lenroot is one of the technical advisers to these delegates.

David Zellerbach represents United States employers; Robert J. Watt, United States workers.

Provision should be made which will lessen the present tendency of the unemployment compensation laws to deter children from returning to school. This can be done by regarding a person of school age as available for work, if he is prepared to accept employment, even though he is attending school. In effect the young worker will be spending his waiting time in school rather than idling his time away. I do not mean that going to school can be used as a subterfuge to avoid working. It would only apply to those who in good faith want to work but cannot secure work and would prefer to study rather than to loaf.

From statement by L. B. Schwellenbach, Secretary of Labor, before Senate Finance Committee, September 1, 1945.

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VOL. 10—NO. 5 NOVEMBER 1945

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The CHILD

CHILDREN'S BUREAU • U. S. DEPARTMENT OF LABOR

- Toward Rehabilitating Crippled Children
- Hospital Nurseries for Newborn
- Can a Migratory Child Go To School?

JAN 3 1946

VOL. 10 NO. 5 NOVEMBER 1945

The CHILD

MONTHLY BULLETIN

Editor Miriam Keeler
Assistant Editor Sarah L. Doran

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The photograph on the cover is by Frank H. Ubhaus

U. S. DEPARTMENT OF LABOR
L. B. Schwellenbach, *Secretary*

CHILDREN'S BUREAU
Katharine F. Lenroot, *Chief*

UNFINISHED BUSINESS

"INFANT MORTALITY," an eminent British physician once said, "is the most sensitive index we possess of social welfare."

For the first time in the history of the country, it is now possible to measure in comparable figures a decade of gains in saving the lives of mothers in childbirth and of babies during their first year of life. Marjorie Gooch tells the statistical story on pages 77 to 83.

On their face, the figures appear to give an optimistic picture. In this 10-year period, the Nation has achieved a 60-percent drop in maternal mortality and a 31-percent drop in infant mortality.

Good as this record is, it is not good enough for a Nation with the scientific and technical know-how that we possess in preventing and curing illness and injury, and with the economic resources we have for developing and providing top-quality services and families for healing and for the saving of human lives.

Over 7,000 mothers died in 1943 from childbearing. Several thousand of these mothers might have been saved. For proof: If every State had had as good a record as the best State—Minnesota—had in that year, nearly 3,000 mothers would not have died.

Over 100,000 babies in 1943 died in their first year of life. If every State had had as good a record as the best State—Connecticut—had in that year 31,000 babies would have been saved.

No one attack will win the battle against this needless loss of life. Gains must be made along a broad front: Improvement in environmental sanitation, safer water and milk supplies, better education of parents in infant care and in the safe preparation of food; assurance of medical care for all mothers throughout pregnancy, at childbirth, and for 6 weeks after birth; assurance of preventive medical care for babies and skilled treatment for them when they become ill.

Two hundred thousand mothers are still delivered in a year without any medical supervision.

A baby's first day of life is his most critical and should be spent in a hospital. While 87 percent of the urban babies are born in hospitals, only half the rural babies are born there. Seventy-seven out of every 100 white babies are born in hospitals, but only 33 out of every 100 nonwhite babies are born there.

One out of three counties has no public-health nurse to advise mothers in their homes on good care for themselves and their babies.

Three out of five counties have no service from full-time public-health units.

A great expansion in the supply of physicians, public-health and hospital nurses, in hospitals and health centers is needed if we are to save the lives of more mothers and babies.

If all mothers had the specialized care from obstetricians that is now available to mothers in big cities, we would need 4,865 more obstetricians.

Sixty percent of our children under 15 are in places of less than 10,000 population where only 4 percent of our pediatricians practice.

These are only some indicators of the unfinished business the Nation has in its great task of building the greatest possible safeguards around the birth of every American citizen. But they point to specific, obtainable objectives.

Until the greatest medical and health skills of which we are capable are made available to all children, regardless of where they live or live or their race, or their economic situation, how can we be content?

Martha M. Eliot

Martha M. Eliot, M.D.
Associate Chief, Children's Bureau

Publication of The Child, Monthly Bulletin, with Social Statistics supplements from time to time, was authorized by the Bureau of the Budget, May 12, 1936, under Rule 42 of the Joint Committee on Printing, to meet the needs of agencies working with or for children for a regular channel of information on current developments, activities, policies, and programs for maintaining the health of mothers and children, providing child-welfare services, and safeguarding the employment of youth. Address The Child, Children's Bureau, U. S. Department of Labor, Washington 25, D. C. The Children's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. The Child is for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at $1 a year; foreign postage, 25 cents additional: single copies, 10 cents.

THE ROAD TO REHABILITATION

Good teamwork by professional workers helps crippled children to lead normal lives

by HELEN J. ALMY
Chief of Public Health Social Work, Massachusetts Department of Public Health

PHYSICIAN, medical-social worker, public-health nurse, physical therapist, teacher, rehabilitation agent—each of these contributes professional skill in helping the crippled child to become a healthy, self-supporting adult. If these skilled workers can begin to help the child early enough, their teamwork may obviate the need for formal rehabilitation measures.

The children whose stories are given here benefited from what might be called "prehabilitation" services, which help to prevent crippling conditions and crippling emotional attitudes. The care was provided through Services for Crippled Children, Massachusetts Department of Health, in cooperation with workers on the staffs of community agencies.

Johnnie would have grown up handicapped; but good professional teamwork prevented crippling

A baby with clubfoot needs to be taken by his parents to the doctor at once. If they accept the instructions that are given them and cooperate with the doctor, the nurse, and the physical therapist in carrying out the treatment prescribed, the condition can usually be corrected so that no handicap results.

Johnnie, a baby born with two clubfeet, was not so easily helped. His parents were poor and ignorant. Their home was crowded, and a new baby was born almost yearly. The family lived in a small town. Johnnie's clubfeet were noticed by the doctor and the nurse at a general clinic where the mother had taken him on account of an eye condition. The clinic doctor told her to take him to the crippled children's diagnostic clinic nearest their home for further examination. When she failed to take him there, the medical-social worker at the general clinic communicated with the medical-social worker in the district health office. This worker and the local public-health nurse persuaded the parents to take Johnnie to the crippled children's clinic. The orthopedic surgeon recommended that Johnnie's feet be operated on.

Then it was the task of the various workers to persuade Johnnie's father and mother to let him be taken to a hospital 50 miles away. The orthopedic surgeon, the clinic medical-social worker, and the public-health nurse explained the situation to the baby's parents, who finally agreed to have the two operations performed at the distant hospital.

The next problem was how to get proper follow-up care for Johnnie after each of the operations. Both the medical-social worker and the public-health nurse felt that good care in the baby's own home would be impossible, and that an arrangement should be made for convalescent care in a foster home near the hospital. Again the nurse who had helped the parents to agree to the operations was called upon. She discussed with the parents the plan for a foster home, and she was successful in getting them to consent. The medical-social worker then enlisted the cooperation of a child-placing agency in making the plans for foster-home care.

After each of the operations Johnnie stayed at the foster home under the close supervision of a nurse and a physical therapist. All the time he was away from home the medical-social worker, the public-health nurse, and the worker for the child-placing agency cooperated in working with the family to make sure that Johnnie's place as a member of the family was not jeopardized.

Johnnie is now expected to grow up without a crippling condition. His experience shows that not only medical and surgical care, nursing, and physical therapy were needed for his physical restoration but also social planning. In spite of the excellent medical and surgical facilities that existed, Johnnie would not have had the benefit of them without the joint work of all the members of the medical team. The home factors would have been too great an obstacle to success.

Peter was on the way to becoming delinquent. Now he is a promising schoolboy

Sometimes the child's crippling is not so serious a problem as the behavior accompanying it, and any successful plan for helping him must include not only orthopedic care but also recognition and treatment of the causes of his behavior.

Peter, 12 years old, had a conspicuous deformity. From birth one leg had been very much shorter than the other. He wore an orthopedic brace, and got around well. Peter was receiving clinic supervision, with the possibility of surgical treatment at some future time.

The public-health nurse in the community where Peter lived learned that his behavior was causing serious difficulty at home and at school. He was defying relatives and teachers, and he was lying and stealing.

The nurse knew that Peter did not have either his father or his mother living with him and suspected that his troublesome behavior was related to his lack of a real family as well as to his crippling. She asked the medical-social worker to look into the situation.

The medical-social worker learned from the local physician and the nurse that Peter's mother had deserted the boy and his father when Peter was 3 years old, and that his father had boarded him with relatives and had gone to live in another town. Peter's behavior difficulties had begun about the time when his father had stopped paying board for him and visiting him and had even stopped writing to him. Peter obviously felt that he had lost status, both at home, where he heard his relatives blaming his father, and at school, where he needed to be able to talk about his dad like the other boys.

It was obvious that some one must help Peter revive the bond with his father and in other ways build up his sense of security so as to get over his difficulties. With the cooperation of a children's agency, the worker arranged to have Peter go to a child-guidance clinic, where he was encouraged to express some of his feelings and to realize that in spite of his handicap he could hold his own at school.

The father was given a better understanding of Peter's needs and was helped to realize how much he could do to benefit his boy. It was impossible for the father to make a home for Peter, but he did begin to write to him, to pay board for him, and to send him occasional presents.

Peter's attitude at home and at school improved. His stealing and lying stopped. Moreover, during his attendance at the child-guidance clinic it was discovered that he was unusually bright and gifted. In a few years he could be expected to make use of vocational-rehabilitation services with marked success.

It is impossible to know how much of Peter's behavior trouble resulted from his crippling condition and how much was connected with his father's desertion and would have been present, handicap or no handicap. His physical handicap no doubt was partly responsible for his feeling that he was not wanted. And the idea that he was not wanted, along with the fact that he was different from other children, had dominated his attitude at home and at school.

Margaret is handling her handicap better now that she has help with her emotional attitude toward it

Sometimes the feeling of being unwanted or different dominates the patient's mind out of all proportion to the severity of the handicap.

Margaret, at 17, had a slight curvature of the spine, which was hardly noticeable when she was dressed. Yet she believed that everyone was staring at her "deformity."

Margaret's extreme timidity and unwillingness to make social contacts attracted the attention of the medical-social worker at a crippled children's clinic. The medical-social worker felt that Margaret's attitude indicated deep-seated problems that needed psychiatric attention. The clinic physician agreed and advised referral to a psychiatrist.

It then became the job of the medical-social worker to get Margaret to understand the need for this kind of help and to want it. But when the social worker first suggested to the girl that she go to a new doctor, who, as the worker phrased it, "might help her to understand better her feeling about her back," Margaret's response was, "If he will make my back straight I will go to him."

After a number of talks with the worker, however, the girl began to feel that it might be good to talk with this new kind of doctor who would help her to understand herself better. She kept her appointment with the psychiatrist and was able to benefit from his treatment. Gradually she showed more courage and willingness to join in social activity.

In preparing the way for Margaret's acceptance of the special services of the psychiatrist, the medical-social worker provided a service that is frequently necessary when the real problem is not so much the crippling condition as the patient's feeling about it.

A LONG STAY IN THE HOSPITAL isn't breaking up Teddy's school career too much. The public schools in his city assign a teacher to this hospital, and all the children who are able to do lessons can keep up with some of their school work.

Photograph by Frank H. Ubhaus

It often happens that a patient does not understand the need for the physician's recommendation. Such a patient does not follow the recommendation merely because it has been made or because an appointment has been obtained. He may need much explanation from the medical-social worker, and an opportunity to discuss his feelings, before he can make good use of the service recommended.

All the members of the medical team share responsibility for recognizing and considering social factors, and all contribute to an understanding of the individual patient. It is the medical-social worker, however, who is expected to take the primary responsibility with regard to the patient's social needs and to initiate planning for them. Her training has been especially concentrated upon understanding the social and emotional factors related to illness and physical handicap.

The problems of the child or young adolescent in relation to physical restoration and later rehabilitation often involve the problems of his father and mother. The attitudes of the child's parents frequently play an important part in his adjustment to a handicap. Parents who are overanxious may stimulate the child to do too much, and those who are oversolicitous may allow, or cultivate in him, an attitude of overdependence. Other parents take little interest in their child and neglect him.

If the mother is overburdened, sometimes social resources in the community can be utilized to get financial assistance or housekeeping service, or to place the child under temporary foster-home care, as was done for Johnnie, the baby with clubfeet.

Sometimes, however, an oversolicitous attitude in the mother, or her lack of interest in the child, may be symptoms of real problems within herself. She may have a feeling of guilt, thinking perhaps it is her fault that the child is crippled. Or she may be full of self-pity because of the restrictions and deprivations that the care of the crippled child has imposed upon her. Or there may be marital difficulties or other family friction.

In such cases an agreement is sometimes made by the nurse or the physical therapist and the medical-social worker for cooperative work. Under this arrangement the nurse or physical therapist works primarily with the child while the medical-social worker may center her attention on the mother or on the other members of the family. Such cooperative service can be very successful if the workers plan and work closely together.

If the mother finds in the medical-social worker a person who is especially interested in her, some one with whom she can talk about her problems, she is likely to be released from some of her tensions and be able to take a more relaxed and wholesome attitude toward the child. As a result the child will have a better chance to grow up psychologically, to become emotionally independent, and to be able to use rehabilitation services when the time comes.

Thus far stories of what might be called "prehabilitation" have been discussed. Two stories will now be presented in which the early steps are followed by successful rehabilitation in the more technical sense of the word. For each of these stories a patient with severe structural scoliosis has been chosen—patients for whom long and repeated periods of hospital care were necessary.

Mike has a straight back and a hopeful future now owing to good teamwork

Mike was 16 when he was referred to a crippled children's clinic. He had a severely deformed back, and he was extremely sensitive about it.

His father and mother were foreign-born and had difficulty both in understanding and speaking English. They had a good deal of Old World fear and suspicion of hospitals, and they would not hear of having the spinal operation performed that the orthopedic surgeon at the clinic recommended. The first job of the clinic workers therefore was to persuade the parents to consent to the operation. This was a difficult task. After some time they said they would consent if the doctor would guarantee a cure. This was a step forward, but it was clear that many additional steps were needed.

The clinic doctor patiently gave the boy and his parents explanations of how much and how little an operation might do. And the physical therapist and the nurse did their part with continued and detailed explanations. Questions and more questions were asked and answered. The medical-social worker, fortunately able to talk with the parents in their own language, had many interviews with them and also with Mike. Sometimes she went to their home in the evening so as to be sure to see the father.

All this took almost 2 years, for the parents, ignorant and fearful, had great difficulty in coming to a decision. At last Mike himself was won over, and after a while his father and mother also agreed to having the operation performed.

At the time Mike was admitted to the hospital, the clinic medical-social worker sent a social summary of his case to the hospital social worker, to help her make the circumstances of the case clear to the physicians and others responsible for his hospital care. The sharing of information between the diagnostic clinic and the hospital can materially help the patient's adjustment to the hospital, especially when there has been resistance to hospitalization.

Mike's hospital career was a great success. The physician saw to it that he was placed near a boy who had already had the type of operation that Mike was to have, and this boy's experience greatly reassured him. Mike made friends among the hospital personnel. A teacher assigned by the local public schools to the hospital gave him lessons.

After a successful operation Mike went home and made a good adjustment there. A home teacher continued his lessons until he was able to return to school. His good adjustment at home was undoubtedly contributed to by the social experience at the hospital—the contacts there with the friendly nurses, doctors, and teacher.

Mike's straight back is a miracle for him and for his family. He tried for the Navy, showing that he felt he was no longer handicapped. He was rejected, to be sure, but he continued to think of himself as a whole man, and he longed to do war work.

Now, a year and a half after his operation, he has a job in the Navy

Yard as apprentice electrician. It is the nearest thing to his ambition—being in the Navy. He seems truly rehabilitated.

Helen is now a self-supporting person instead of a crippled dependent

Another patient with a severely deformed back, whom the State crippled children's agency saw through to successful rehabilitation, was a girl named Helen, who did not come to the attention of the diagnostic clinic until she was 18 years old—almost too late. At that time she was a very lame, crooked little person, with an alert, attractive face and a friendly manner. The orthopedic surgeon at the clinic predicted that unless treatment was provided promptly her legs might become paralyzed.

Conditions in her home were bad. Her mother was dead, and her father was alcoholic and was irregularly employed. She had four younger brothers. Helen was trying to keep house for this family with only casual help and supervision from an aunt living nearby. In spite of all these difficulties, there was a strong family affection.

Helen and her family accepted the doctor's recommendation that an operation should be performed, and she was brought to one of the Boston hospitals.

From the medical-social worker's report the physician realized that proper supervision and follow-up care could not be given Helen in her own home, and therefore convalescent care was arranged in a home in Boston.

While Helen was at the hospital and the convalescent home the public-health nurse received reports on her progress from the medical-social worker and kept the family informed.

After going home Helen resumed her heavy home duties too soon; whereupon the medical-social worker made arrangements for her to live for a while away from home at a special school. In her absence the aunt looked after the younger children, and the public-health nurse continued to visit the home for general oversight.

Helen had expressed a desire to become a beauty-shop operator, and so the worker referred her to the district representative of the State vocational - rehabilitation services, who arranged for the training. Thus the young girl learned that she could support herself.

Temporarily Helen took a job in a plant producing war materials, but she expects to return to the beauty-shop work for which she has been specifically trained.

To carry out the various steps of medical care, convalescence, schooling, vocational rehabilitation for Mike and Helen, many professional people contributed. First, of course, was the physician. But the other clinic personnel, the health and welfare workers in the local communities, the hospital and convalescent-home personnel and the rehabilitation workers all played important parts. The chief role of the medical-social worker in the crippled children's agency was to mobilize and coordinate these services so that there was continuity in the medical and social plan and consistent guidance toward the ultimate goal of successful rehabilitation and placement in a job.

Sometimes a medical-social worker in a crippled children's program is asked to define the social problems that she believes should be referred to her. It is difficult to make such a definition, for a problem that calls for the medical-social worker's services is not basically the problem of the crippling condition. It is the reaction of the individual to his condition, and this reaction depends on the resources at his disposal—within himself, in his family, and in his community.

To be sure, a crippling condition probably always creates a problem. Many an individual, however—astonishingly many — finds strength within himself through which he meets his problem and can use the services and facilities in his community to become, within the limits of medical science, physically restored and in every way rehabilitated. Such a person, if given the information regarding the necessary resources—orthopedic nursing, physical therapy, educational, rehabilitation—is in a position financially and emotionally to take advantage of them. Other persons, however, because of unfavorable conditions in the community, in the family, or in themselves, need special help in taking one or more of the steps along the road toward rehabilitation. If they do not get this help the medical care they receive will not be effective and the possibilities of rehabilitation will not be utilized. Betsey Barton in her recent book, "And Now to Live Again," has described the task that confronts persons to whom a severe crippling handicap has come. She speaks of the agonizingly slow mental adjustment that must be made to reach the victorious state of mind so necessary in coping with a new and terrifying world.

To sum up.—Successful rehabilitation of the physically handicapped individual includes: (1) the optimum of physical restoration. (2) personal and emotional adjustment to handicap. (3) vocational guidance and training for those who can benefit from them. But the social problems related to disability must be treated as well as the organic impairment if either medical care or rehabilitation is to be effective.

The program must meet the needs of the individual. Each patient comes from a different background and presents a condition and attitude peculiar to himself.

All the members of the medical team have a responsibility for recognizing and considering social factors affecting the individual. The role of the medical-social consultant in a State crippled children's program is threefold: To mobilize and help to coordinate services of the social and health agencies, to act as consultant in the area where medical and social factors come together, and in certain cases, to give direct service to the patient. The aim of all is rehabilitation. Any program that fails to plan for the social as well as medical rehabilitation of the crippled person and his eventual placement in the niche where he can best function falls short of its real objective.

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SCHOOL DOORS BEGIN TO OPEN TO THE CHILDREN OF MIGRATORY FARM WORKERS

A few communities show the way education can be put within their reach

by IONE L. CLINTON, Industrial Division, U. S. Children's Bureau

MANY A CHILD in a migratory farm family never learns to read and write. Some never learn to speak English. We may find this hard to realize, because we assume that all children in this country are required to go to school until they have completed a certain grade or reached a certain age set by the laws in their State. Indeed, we sometimes boast that all our children have an opportunity to get the full benefits of the American standard of education.

Our boasts sound empty against the hard fact that up to June 1, 1944, nearly 600,000 men 18 through 37 years of age had been rejected for military service because of educational or mental deficiency—a large proportion of whom were able to learn but had not had enough schooling to pass a fourth-grade test established by the military authorities.

Evidence of the lack of opportunity for migratory children has been found again and again over a period of years, in different parts of the country, in the course of studies made by such agencies as the National Child Labor Committee, the United States Office of Education, and the Children's Bureau and through information obtained from many different sources.

In one such study, made in Hidalgo County, Tex., in 1941, by the Children's Bureau and the United States Office of Education, the investigators found that of about 1,000 migratory children 6 through 17 years of age, who at the time of the study were living in their home communities, 500 were not enrolled in school, and 163 had never gone to school at all. About one-fourth of those who had never gone to school were 12 years of age or older and probably never would go to school.

Every year thousands of farm laborers and their families migrate from Texas to Michigan to work on the sugar beet crop and to harvest fruits and vegetables. Many migrate from other places too. How little schooling the children of these workers get is suggested by figures from 14 counties, published in the University of Michigan's School of Education Bulletin, October 1943. The author, Edgar G. Johnston, who called his study "Michigan's Stepchildren," found that although the school census for the 14 counties included 2,570 migratory children only a little more than one-fourth were enrolled in school at the time the information was collected.

Such reports confirm the statements of many persons who see these children working when they should be in school and who are acquainted with the children and know how illiterate or near-illiterate many of them are.

Why do so many of these children never go to school at all? And why is it that those who do start school are unlikely to complete more than a few grades?

Let us look at some of the reasons.

What children are up against

When other children are in school large numbers of migratory farm children of school age are planting, weeding, or harvesting crops to eke out the meager income of their parents. Or else they are at home taking care of the babies and toddlers

A SCHOOL BUS has just carried these children from their school in a nearby city to their temporary homes in a farm-labor supply center in Texas. Their older brothers and sisters and their parents are in Texas to pick vegetables.

Photograph by Rothstein, Farm Security Administration

in the family while the older members of the family are in the fields.

It is just about impossible for a migratory family to remain in one locality long enough to permit the children to go to school for a full school term, for the families are needed to work in one locality after another—often at great distances—as one crop after another reaches its peak. In the winter months, which most of us think of as school time, the migratory farm family is likely to be working in States with a warm climate, harvesting oranges and grapefruit and many kinds of vegetables. In the spring they may be picking strawberries; in the fall, cotton in some States, apples in others.

Some migratory children go to school when they are in their home communities. Their home communities, however, are very likely to be in parts of the country where crops are harvested in the winter months. And even after a youngster reaches home and starts school—it may be from 1 to 3 months late in the term—he leaves school from time to time and works in the fields. And by March or April the family starts out again and the child leaves school.

In one locality the district school superintendent reports that last year a school in his district opened in the first week of September with only 30 per cent of the children in the community present. By December nearly all of the children had come to school, but by the middle of April attendance had dropped to only 40 per cent. The rest of the children had either left the community or were working in the onion fields nearby. Another school in the district had already closed by that time because all the children had left the community with their families to follow the crops.

A few migratory farm families try to give their children some schooling in the various communities along their migratory route. But during the harvest season many rural schools close to release the local children for work in the fields. This of course interferes with the schooling of the local child but is much more of a handicap to the migrant child, who may find the schools closed in most of the places where he stops.

If the schools are open and the migratory child enrolls he may not be in school a month until, just as he did in the home community, he must leave school and move on with his family. This may happen again and again and may keep the child from ever completing a grade or even a school project he has undertaken.

It is discouraging to the children to be taken out of school before they have completed a school term and it is equally discouraging when they have to enter a new school—almost certainly one with different content and rate of progress—in the middle of a school term.

As a result of the need to migrate the child drops behind his own age group and does not progress from grade to grade as does the child who attends the same school regularly.

What schools are up against

Because the children change schools often and because they attend so irregularly, teaching them becomes a special problem.

There are other reasons why it is difficult for schools to absorb these children, some of which are the result of their way of life.

Often the children are poorly dressed. They may be in ill health because of lack of sanitation, bad food, and the absence of medical care. Often because of poor living conditions and despite the efforts of their parents, the children are not clean. In addition a considerable number of migratory farm families speak a foreign language only and understand little English. Another considerable group of migrants are Negroes.

For these reasons and others, schools may refuse to accept migrant children. They may do this because they have no room for the migrant children, because they are unable

SUNSET SCHOOL is located in a Federal farm-labor supply center at Arvin, Calif. It was planned only for migratory farm children staying at the center, but now it is attended also by children who live permanently in the community.

Photograph by Leo B. Hart, Superintendent of Schools, Kern County, Calif.

to cope with their special needs, or because they do not feel obliged to take them in.

Bringing children and schools together

A number of efforts have recently been made to overcome the obstacles—work during school hours, irregularity of school attendance, and lack of community acceptance—that stand in the way of real educational opportunity for them.

Special funds provided.—An occasional State has enacted legislation for special State aid for schooling for migratory children. In 1943 New Jersey passed a law to apportion to each school district $45 for each child of a farm worker not a resident of the State who attends. At present this provision has a time limit but consideration is being given to making it permanent. California for some years has had permanent legislation that provides special funds to aid counties in providing for emergency schools for these children.

Larger earnings by parents help.—Temporarily at least, the better wages and steadier work of the war years have reduced the pressure of family poverty that forces children to work in the fields and to lose schooling.

A Texas welfare officer reports that some fathers in his county were earning enough last year to leave their families in their home communities so that the children could go to school during December and January while the fathers picked carrots in a nearby county.

A Government agricultural station through which many farm families pass on their migratory route reports that a few families with children returned earlier than usual from cotton picking in the fall of 1944. The parents said that they were doing so in order to give their children a better chance to enter school and that they were able to do so because their earnings were larger than usual. But even these parents, in order to earn their scant living, had to take their families away from home for considerable periods of the year and the schooling of their children still suffered.

Local communities are experimenting. — Some communities in which migatory farm families live during the time they are harvesting crops are making efforts to find out the best ways to give the children in these families an opportunity to go to school. They have found that a very important factor in getting them into school is to make the children feel themselves a part of the community.

How the community can help the agricultural migrant to feel a part of the community and can interest the children in these families in attending school is shown by an experiment in Kern County, Calif. An elementary school was set up some years ago, with special funds provided by the State, for the children of workers in a Federal farm-labor supply camp at Arvin, Calif.

Through the years this school has grown in size and strength, has found a permanent place in the community, and has brought the people of the community and of the camp together. Neighboring farmers contribute pigs, rabbits, cows, sheep, and chickens to the school for the school lunch; the children learn to take care of the animals. Last year a swimming pool was built on the school grounds by the older boys, with the principal directing them and working with them. This pool is now also used by the community.

The county school superintendent reports that this year the upper-grade children of both groups of families—the families in the camp and those with permanent houses in the community—will attend the camp school together, and the lower-grade children of both groups will attend the district school.

Another effort to draw the migratory families into the life of the community and to study the special needs of the children and find out how to meet them was made by the Central Michigan College of Edu-

Absolutely
E ALLOWED IN
UNLESS - LIFE
IS ON DUTY.

THIS SWIMMING POOL was built by the older boys of Sunset School, with the help and direction of the principal. The pool is used by the townspeople of Arvin, as well as by the migratory workers staying at the farm-labor supply center.

Photograph by Leo B. Hart, Superintendent of Schools, Kern County, Calif.

cation, Mt. Pleasant, Mich., during the summer of this year. The college established an experimental elementary school lasting 6 weeks. Interest in setting up the school was stimulated by the work of the Home Missions Council among migrants. These migrants, many of Mexican heritage, had been coming to the community for years to work in the beets from May to November. The Office of Inter-American Affairs financed the school. The college transported the children in the college bus, and the city schools cooperated by permitting the use of a school building for the session.

The group of 31 children from 6 to 12 years of age who attended this experimental session was made up of 16 migrant children and 15 children who lived in the community. Many of these migrant children spoke Spanish only and understood very little English. Because of this additional handicap they were even shyer of strangers than the usual migratory child, and more effort was needed to make them feel a part of the school. Opportunity for speaking both Spanish and English was given all the children — thus the English-speaking children became aware of the language skill of the Spanish-speaking children. One of the members of the teaching staff was a young woman who herself had come to Michigan as a child with her parents and brothers and sisters to do seasonal work; the children went to school and the family stayed on in Michigan. This young woman recently graduated from Central Michigan College of Education.

School services are being extended to migratory workers.— In Saginaw County, Mich., the county school commissioner for some years has been enlarging the teaching staff to take care of the migratory children while they are in the community. Each year, the commissioner has engaged one extra teacher; and two more such teachers will be engaged this year for the 3 months that the migratory workers will be in the county. The fathers and mothers of the migratory children are made welcome at the local parent-teacher association meetings.

Another example of extending school services to seasonal farm workers' children can be found in the visiting teacher service of a school district in Texas, which thousands of seasonal farm workers consider their home community. This community now employs a Spanish-speaking visiting teacher to call at the home of children who have dropped out of school and to urge them to return. She investigates and reports on the economic status of the family; the health of the child; the sleeping accommodations, food, and clothing available to the child; and all other matters that may affect his school attendance. She gives the family advice as to how to overcome the handicaps to the child's attending school and if, after her first visit to the home the child does not come back to school, she returns again to see what more she can do.

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If migratory farm children are to have an opportunity to get schooling equal to that recognized as the right of all American children, the conditions that deny migratory children this opportunity must be overcome. The protection of child-labor laws, as well as effective compulsory school-attendance requirements, are fundamental to broad attack on the problems of educating migrant children.

Moreover, additional facilities and services are needed so that schools can take in the additional children without curtailing school services to nonmigratory children.

In the meantime much more experimentation—and by many more communities—is needed to find out the best way to enable the migrant child to feel welcome in the school.

And most of all, a sound program of national planning and of cooperation among States is needed to give such children an opportunity for a good education.

EVERY RURAL CHILD HAS THE RIGHT

1. **To a satisfactory, modern elementary education**
2. **To a satisfactory, modern secondary education**
3. **To an educational program that bridges the gap between home and school, and between school and adult life**
4. **Through his school to health services, educational and vocational guidance, library facilities, recreational activities, and, where needed, school lunches and pupil transportation facilities at public expense**
5. **To teachers, supervisors, and administrators who know rural life and who are educated to deal effectively with the problems peculiar to rural schools**
6. **To educational service and guidance during the entire year and full-time attendance in a school that is open for not less than 9 months in each year for at least 12 years**
7. **To attend school in a satisfactory, modern building**
8. **Through the school to participate in community life and culture**
9. **To a local school system sufficiently strong to provide all the services required for a modern education**
10. **To have the tax resources of his community, State, and Nation used to guarantee him an American standard of educational opportunity**

—A Charter of Education for Rural Children.
First White House Conference on Rural Education, October 3-5, 1944.

A limited supply of reprints of this article will be available from the Children's Bureau, Washington 25, D. C.

UNIVERSITY HOSPITAL PREPARES TO GIVE BETTER CARE TO NEWBORN BABIES

New nurseries aim to prevent epidemics and foster mother-baby relationships

HOSPITAL NURSERIES for newborn babies, planned to protect the baby from infection, to facilitate nursing care, and to help the mother get acquainted with her baby early are described in *The Modern Hospital* for July by Dr. P. A. McLendon, professor of pediatrics at George Washington University School of Medicine, Washington, D. C., and Dr. John Parks, professor of obstetrics and gynecology at the same school.

This plan is being carried out in the new George Washington University Hospital, Washington, D. C. Every baby's crib is to be placed in a separate cubicle, with glass partitions between cribs. The largest number of cribs in a single nursery will be eight, and no more than eight babies will be taken care of by a nurse at one time. The mothers' rooms are to be located near the nurseries, so that every mother can have her baby with her much of the time. Separate nursing units will be provided for premature babies and for babies showing any evidence of infection.

It has taken epidemics of impetigo, respiratory infections, and more particularly "neonatal diarrhea," to bring about a demand for changes in the architecture of hospital nurseries, say the authors, adding that hospitals in all parts of the United States have experienced the disaster of one or more of these tragic nursery epidemics.

In this connection the article notes that in the 8-year period 1935-42 the number of women who gave birth to their babies in hospitals increased by more than four-fifths. During that time the maternal mortality rate decreased more than half, but the mortality rate among infants in their first month of life decreased only a fifth.

The mortality rate for infants dying in the first month of life can and should be reduced a great deal, say Drs. McLendon and Parks, and improved nurseries can contribute to a real reduction in the neonatal deaths that result from preventable diseases.

Many hospitals, recognizing the danger to the babies that results from large nurseries, have built partitions to break up their nurseries into smaller units, the article says. Many of the made-over nurseries, however, lack proper plumbing facilities, adequate examination and treatment rooms, and necessary bedside working space. These deficiencies have made physicians conscious of the need for radical changes in the design for hospital nurseries.

Foremost of these changes, say the authors, must be provisions for protection against infection. In addition, the structure of nurseries should be changed so they not only serve as protected quarters but contribute as maternal centers of education in infant care and development.

A nursing assignment under the plan will consist of one eight-crib nursery, or two four-crib nurseries, or eight one-crib nurseries. Irrespective of the size or location of these units, the article says, no infection need spread from one to the other of these independently arranged nurseries without gross neglect in supervision.

The mothers' rooms are planned in relation to the nurseries so that the baby can be rolled to his mother's room in a mobile bassinet, with a minimum of corridor travel, as this exposes him to infection.

Under this plan the mother will have the privilege of seeing "the early developmental changes that characterize the newborn and that can be appreciated only through more prolonged periods of observation than has been the practice in the hospital care of infants."

The mother will also have an early opportunity to learn from her nurse what Drs. McLendon and Parks call the "simple but disturbing first lessons" in breast or bottle feeding, in eructating the baby, changing his diaper, bathing him, and otherwise caring for him.

It is understood that the baby will not be left in the mother's room during visiting hours and that visitors will not be allowed to enter the room during nursing periods.

Every nursery for normal infants will provide 25 square feet of floor space for each baby.

Floors, walls, and partitions are to be constructed so that there will be a minimum of ledges that catch dust and of areas inaccessible for cleaning.

All partitions will be of clear glass so that a full view of the entire area may be had from any point. Each nursery will have an individual wall light in each cubicle, and also ceiling lights hooked up to a constant dim light and a switch for indirect floor lighting. Each cubicle will have its own "plug-in" for use in attaching any necessary electrical devices.

Attached to every nursery will be an examination-treatment room, as well as a separate chart and gowning room. In the latter room the physician may examine the baby's record and look at the baby through the glass partition.

Lavatories will be located in every nursery, examination-treatment room, and chartroom.

View windows, with opaque sliding panels, will permit visitors to see the babies.

Two four-crib nurseries will be placed opposite each other on a corridor, so that a nurse can supervise the care of eight babies. Each four-crib nursery will be placed between two double rooms for mothers, and viewing windows will be placed between the mother's room and the nursery.

As one step further in the idea of smaller nursery units and closer mother-baby relationships, one wing of the hospital will have individual nurseries, each connected with the mother's bedroom. Each of these individual nurseries has a viewing window between the nursery and the corridor, so that one nurse can observe all eight babies without disturbing the mothers. A few of the mothers' rooms will have bath facilities also.

Turning to the cost of hospital care, the mother's room and the infant's nursery space should be considered separately, say Drs. McLendon and Parks. Charges for infant care in voluntary hospitals rarely pay for nursery costs, they add, and under any acceptable standard good nursery care is expensive. In hospital economy, according to the authors, the infant should be treated as the important end-product rather than a by-product of the maternity division.

In their conclusions, Drs. Parks and McLendon stress the point that small functional units are the surest means of controlling nursery infections. With regard to the effect of locating the mothers' rooms near the nurseries, the authors remark that encouragement in the early mother-baby relationship should be a tremendous factor in breast feeding. The pendulum of ultramodern scientific management of early infancy is slowly but surely swinging back toward a more rational and normal attitude, they continue. In an atmosphere of hospital helpfulness, they say, this new nursery design will develop in the mother more confidence in herself and a better understanding of her infant than have been possible in previous hospital practices.

The article in *The Modern Hospital* includes floor plans for nurseries for normal babies—an eight-crib unit, a four-crib unit, and a single nursery attached to the mother's bedroom; also floor plans for a premature nursery suite.

By permission of *The Modern Hospital* the Children's Bureau has reprinted the article that is summarized here, and single copies of the complete article, including the floor plans, may be had without charge by writing to the Bureau.

C. B. NEWS NOTES

Chief of Children's Bureau Appoints Advisory Committee of Trade Union Women

On August 22, 1945, the Chief of the Children's Bureau announced the appointment of an Advisory Committee of Trade Union Women, consisting of eight women representatives of labor unions affiliated with the American Federation of Labor and the Congress of Industrial Organizations. This committee will consult with the Bureau on the formulation of programs affecting women workers and their children and employed young people and on methods of informing the unions of these programs.

The subjects under special consideration at the first meeting of the committee, which was held on September 25, included needs for continuing facilities for day-care of children of women workers; union plans for participating in efforts to expand community services for children and youth; and measures needed this year to keep boys and girls in school, protect young workers, and help in the readjustment of young war workers who lose their jobs.

Adviser on Dental Services Appointed on Staff of Children's Bureau

The appointment of Dr. John T. Fulton to the staff of the Children's Bureau as adviser on dental services was announced on September 12. This is the first time that the Bureau has had a specialist in this field on its staff, although Federal funds for maternal and child-health services have been available to State health agencies for the provision of dental-health services for mothers and children since the Social Security Act was passed in 1935.

Dr. Fulton, who is attached to the Division of Research in Child Development, will conduct research on the needs of children for dental care, methods of providing care, and standards of training for dental personnel. He will also work with the Division of Health Services, giving consultation service to State health agencies on the extension and improvement of dental-health services for children and pregnant women.

Dr. Fulton comes to the Children's Bureau from the Connecticut State Department of Health, where he had been Chief of the Division of Dental Hygiene since 1942.

Children's Bureau Advisory Committee on Statistics Concerning Children

The Children's Bureau Advisory Committee on Social Statistics has been reconstituted as the Advisory Committee on Statistics Concerning Children, in order to relate it more closely to the Bureau's entire program of statistical research. As originally constituted the committee served as an advisory body to the Children's Bureau on the collection of health and welfare statistics in urban areas through the social-statistics project, for which the Children's Bureau terminated its responsibility as of June 30, 1945.

The reconstituted committee functions through two subcommittees—one on child-welfare statistics, the other on juvenile-deliquency statistics. The expansion of the committee through the addition of other subcommittees is contemplated in the future.

The subcommittee on juvenile-delinquency statistics began its work with a reconsideration of the reporting of juvenile-court statistics. Proposals for reorienting and amplifying these reports on the basis of the committee's recommendations have been sent out to State agencies concerned with juvenile-court statistics by the Bureau for comments and suggestions.

The subcommittee on child-welfare statistics at its first meeting considered various problems connected with the improvement and extension of current reporting of statistics by State agencies administering child-welfare services.

TEN YEARS OF PROGRESS IN REDUCING MATERNAL AND INFANT MORTALITY

With figures showing changes in the rates between the 2 years 1942-43

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WITH PUBLICATION by the Bureau of the Census of data on births and deaths for 1943, it is possible for the first time to compare infant and maternal mortality rates over a 10-year period. Although much information on these subjects has been available for a number of years, the first year in which reasonably satisfactory data were available for every State in the Union was 1933.

Between 1933 and 1943 the maternal mortality rate declined 60 percent—from 61.9 deaths directly due to pregnancy and childbirth in 1933 per 10,000 live births to 24.5 such deaths in 1943. The infant mortality rate during the same years dropped from 58.1 deaths of infants under 1 year of age per 1,000 live births to 40.4 in 1943—a decrease of 31 percent.

The reporting of these comparable figures for the entire United States is a milestone in the history of vital statistics.

Development of birth and death registration in this country has been a long, slow process.

The first vital statistics published by the Federal Government were for the year 1850; these were based on data collected during the decennial population census of that year. Although the information covered the entire United States, the method of obtaining the data made it inevitable that they would be incomplete and inaccurate.

In some of the earlier-settled States, official registration of certain facts about births and deaths at the time the birth or death occurred had been in force since early colonial times. This principle—registration rather than enumeration—was used in the establishment in 1900 of the death-registration area. Only 10 States, the District of Columbia, and a small number of cities were included in this first registration area. But even this small beginning required that some central agency be given responsibility for the annual collection, compilation, and publication of the information. The Bureau of the Census was given this responsibility, and from this small beginning the structure of the present-day vital statistics has grown up. Similarly a birth-registration area was begun in 1915, with only 10 States and the District of Columbia included. Gradually States were added to each of these registration areas until in 1933 all the States were included in both the birth- and the death-registration areas.

Admission of a State to either registration area required proof that certain standards of completeness of registration had been met.

The registration procedure—that is, the filing of an official document giving specified information about the birth or death soon after it occurred—involves many persons and procedures. The certificate is filed with a local registrar, forwarded by him after he has made a record of certain facts, to the State registrar. In the office of the State registrar copies are made of the statistical information and sent on to the Federal Bureau of the Census which makes the Nation-wide tabulations and analyses of the data.

It is obvious that with the millions of records involved each year, definite classifications of many items must be agreed upon. Sometimes it becomes necessary or advisable to change some of the definitions and when this is done direct comparisons of current data with those published earlier are sometimes difficult or even impossible to make.

The classifications of causes of death are made according to the International List of the Causes of Death. This list is revised every 10 years to keep pace with advancement in medical knowledge. The latest revision was made in 1938, and deaths that occurred from 1939 through 1943 were classified according to this latest edition. Deaths that occurred from 1933 through 1938 were classified according to the 1929 edition. There were more extensive changes in the classification of causes of maternal deaths than of infant deaths, but the major discrepancies brought about by the revision have been overcome by the use of broad groups of causes. There are hidden variations, however, that cannot be corrected by this practice.[1]

Another change which was made in the tabulations of the Bureau of the Census during the 10-year period from 1933 to 1943 was the change from a place-of-occurrence to a place-of-residence basis. From 1933 through 1936 all births and deaths were tabulated according to the place where the birth or death took place. Data tabulated according to place of residence, however, have much more public-health significance. For this reason, from 1937 on most tabulations have been made on this basis. This change does not affect the statistics for the United States as a whole, except those relating to urban and rural areas. For most States, figures for births and maternal and infant deaths are not greatly different whether on an occurrence or on a residence basis. The Bureau of the Census has continued to publish some data on an occurrence basis as well as on a residence basis. For data that are not available on an occurrence basis direct comparisons between 1933 and 1943 for geographic subdivisions are not valid.

As a whole, however, in spite of limitations, the figures for both maternal and infant mortality are comparable.

Before examining the mortality rates, let us look at the figures for births during the decade 1933-43.

BIRTHS

Birth rates

In the 10 years from 1933 to 1943 there was an increase in the birth rate of 30 percent. For 1933, 2,081,232 live births were registered in the United States; this meant a birth rate of 16.6 per 1,000 estimated population. For 1943, 2,934,860 live births were registered—a birth rate of 21.5 per 1,000 estimated population including the armed forces overseas.

The birth rates for the United States from 1933 to 1943 are as follows:

Year	*Rate*
1933	16.6
1934	17.2
1935	16.9
1936	16.7
1937	17.1
1938	17.6
1939	17.3
1940	17.9
1941	18.9
1942	20.9
1943	21.5

Race

The proportion of Negro births decreased slightly from 1933 to 1943. In the earlier year 11.8 percent of all live births were Negro; in 1943, 11.1 percent. In both years Mississippi had the highest proportion of Negro births (54 percent in 1933 and 53 percent in 1943). Idaho and North Dakota had less than 0.1 percent in each year. The greatest concentration of Negro births occurs in fewer than one-fourth of the States and during the 10-year period there was little change in the picture. Between 1933 and 1943 the States with the highest proportion of Negro births showed a slight decrease in this proportion. In other words, there has been a shift in the Negro population away from the southern States.

Attendant at birth

Data for 1933 on the number of births occurring in hospitals and attended by physicians are not available from the Bureau of the Census, but from data published in the Journal of the American Medical Association for March 31, 1934, it seems probable that in 1933 less than 35 percent of the births took place in hospitals. By 1943 this percentage had risen to 72 percent.

The percentage of hospital births from the first year for which such data are available from the Bureau of the Census to 1943, and the percent increase from each year to the next, are as follows:

Proportion of Births in Hospitals

Year	*Percentage of all live births*	*Percent increase*
1935	37	
1936	41	10.8
1937	45	9.8
1938	48	6.7
1939	51	6.3
1940	56	9.8
1941	61	8.9
1942	68	11.5
1943	72	5.9

The proportion of hospital births increased 95 percent during this period. More complete data for 1935 and 1943 are given in table 1.

The increase in proportion of hospital births has been more pronounced for whites than for Negroes when the entire 8-year period is considered. Between 1942 and 1943, however, the proportion of Negro births in hospitals increased 10 percent while that for white births increased only 6 percent.

In 1943 the proportion of births occurring in hospitals (table 2) ranged from 97.3 percent for Connecticut to 26.6 percent for Mississippi. Thirty-two States had a higher proportion of hospital births than that shown for the United States as a whole.

Urban and rural

Since hospital facilities are largely located in urban areas, the natural corollary to the increased proportion of births in hospitals would be an increase in births *occurring* in urban areas. Table 3 shows that in 1943 73 percent of all births occurred in urban areas, but only 58 percent of the mothers lived in urban areas. In other words, 15 percent of the women having babies in 1943 lived in rural areas but went to cities for care during delivery.

MATERNAL MORTALITY

In 1933 there were 12,885 women who died from causes directly due to pregnancy and childbirth. In 1943 this number had dropped to 7,197; the risk of dying from these causes was actually reduced more than is indicated by the difference between these figures, because there were over 800,000 more births in 1943 than in 1933.

The number of puerperal deaths per 10,000 live births declined from 62 in 1933 to 25 in 1943—a reduction of 60 percent, which is highly significant statistically. The differences between the maternal mortality rates by race are as follows:

Maternal Deaths per 10,000 Live Births

	Total	*White*	*Negro*	*Other*
1933	61.9	56.4	100.0	76.2
1943	24.5	21.1	51.3	44.6
Percent change	*—60.4*	*—62.6*	*—48.7*	*—41.5*

Although for this total 10-year period there was a greater reduction in maternal mortality for whites than for Negroes, nevertheless, from 1941 to 1943 the rate for Negroes decreased more sharply than that for whites, as is shown in the following comparison.

Percent Change in Maternal Death Rates

	1941–42	*1942–43*
Total	—18	—5
White	—17	—5
Negro	—20	—7
Other	+ 3	+3

The reduction in maternal mortality is even more striking than the total figures show because during the later years of the decade 1933 to 1943 there was an increased proportion of first births and of births to young mothers, both of which factors are known to be associated with high maternal mortality.[2]

Age at death

The proportionate reduction in maternal mortality for each age group is shown in table 4. The smallest reduction occurred among mothers under 15 years of age and the largest reduction among those 20-24 years. The latter age group showed the lowest maternal mortality rate both in 1933 and in 1943.

The higher mortality in the very young group may be the result of less prenatal supervision and a high percentage of first births, as well as relatively incomplete physiological development. It is possible that in 1943 somewhat more adequate prenatal care was available to this group than in 1933 and that as a result the rate was reduced. But apparently, other factors associated with high maternal mortality rates, such as physiological immaturity and parity, made the reduction in the rate less pronounced for

Table 1.—Number and percent of births, by race, according to person in attendance, live births; United States, 1935 and 1943

Race	Live births	Number attended by—			Percent attended by—		
		Physician		Nonmedical attendant	Physician		Nonmedical attendant
		In hospital	In home		In hospital	In home	
1943							
All races	2,934,860	2,115,582	615,754	203,524	72.1	21.0	6.9
White	2,594,763	2,002,313	534,177	58,273	77.2	20.6	2.2
Negro	324,865	102,152	79,405	143,308	31.5	24.4	44.1
Other	15,232	11,117	2,172	1,943	73.0	14.3	12.7
1935							
All races	2,155,105	795,629	1,089,832	269,644	36.9	50.6	12.5
White	1,888,012	746,974	1,019,271	121,767	39.6	54.0	6.4
Negro	255,124	44,059	66,218	144,847	17.3	25.9	56.8
Other	11,969	4,596	4,343	3,030	38.4	36.3	25.3

Table 2.—Percent of births, by person in attendance, live births; United States and each State, 1943

Area	Percent attended by—		
	Physician		Nonmedical person
	In hospital	In home	
United States	72.1	21.0	6.9
Alabama	34.5	40.1	25.4
Arizona	77.5	13.9	8.6
Arkansas	35.1	45.0	19.9
California	93.8	5.6	.6
Colorado	77.5	20.7	1.8
Connecticut	97.3	2.6	.1
Delaware	81.1	11.8	7.1
District of Columbia	92.9	7.1	(1)
Florida	61.8	18.5	19.7
Georgia	45.5	27.6	26.9
Idaho	87.6	12.3	.1
Illinois	87.6	12.2	.2
Indiana	75.6	24.3	.1
Iowa	79.0	20.9	.1
Kansas	78.2	21.7	.1
Kentucky	33.3	55.2	11.5
Louisiana	54.5	21.3	24.2
Maine	75.9	23.6	.5
Maryland	70.7	23.9	5.4
Massachusetts	93.8	6.2	(1)
Michigan	84.3	15.5	.2
Minnesota	85.6	13.9	.5
Mississippi	26.6	30.6	42.8
Missouri	64.3	32.9	2.8
Montana	91.4	7.1	1.5
Nebraska	78.8	21.1	.1
Nevada	92.5	6.6	.9
New Hampshire	89.9	10.1	(1)
New Jersey	91.0	7.4	1.6
New Mexico	50.2	27.8	22.0
New York	93.7	5.7	.6
North Carolina	45.7	36.4	17.9
North Dakota	81.2	17.3	1.5
Ohio	80.4	19.5	.1
Oklahoma	61.3	34.9	3.8
Oregon	95.6	4.1	.3
Pennsylvania	77.9	21.9	.2
Rhode Island	89.2	10.3	.5
South Carolina	35.7	28.0	36.3
South Dakota	77.0	21.2	1.8
Tennessee	42.2	50.2	7.6
Texas	61.7	24.5	13.8
Utah	87.5	12.1	.4
Vermont	75.0	24.9	.1
Virginia	50.7	32.5	16.8
Washington	96.4	3.4	.2
West Virginia	38.1	58.4	3.5
Wisconsin	83.3	16.5	.2
Wyoming	87.9	11.7	.4

[1] Less than 0.1 percent.

Table 3.—Live births, urban[1] and rural, United States, 1933 and 1943

Area	1933		1943			
	Occurrence		Occurrence		Residence	
	Number	Percent	Number	Percent	Number	Percent
Total	2,081,232	100	2,934,860	100	2,934,860	100
Urban	1,142,596	55	2,137,941	73	1,714,164	58
Rural	938,636	45	796,919	27	1,220,696	42

[1] Urban places are those having 2,500 or more population at the last population census.

this age group.

At the other end of the age scale, the high rates for older mothers are undoubtedly the results of complicating diseases and the effects of multiparity.

Causes of maternal deaths

It is gratifying to know that for the first 10 years of Nation-wide birth and death registration such a dramatic reduction in the maternal mortality rate took place and that the age usually considered most favorable for maternity was even less hazardous in 1943 than it was in 1933. Is this reduction due to uniform reduction in all causes of maternal death or have deaths from certain causes been reduced more than those from other causes? Unfortunately the comparison of causes of maternal deaths is extremely difficult because of the extensive changes made in the International List for the puerperal causes.

1933-43—Comparison of deaths due to infection and to toxemia can be made with considerable accuracy for the years 1933 and 1943 but comparison of deaths due to hemorrhage is not valid.

When the maternal deaths for 1933 and 1943 are reclassified to make them as nearly comparable as possible, it is found that the proportion of deaths due to infection and to toxemia did not change markedly. The reduction in the maternal mortality rate due to infection was, however, greater than the reduction in that due to toxemia, as may be seen from the following comparison:

MATERNAL DEATHS PER 10,000 LIVE BIRTHS

	All causes	*Infection*	*Toxemia*	*All other*
1933......	61.9	23.5	14.7	23.7
1943......	24.5	8.8	6.2	9.5
Percent change .	*—60.4*	*—62.6*	*—57.8*	*—59.9*

The actual decrease in the rate from infection may be even greater than the figures indicate since deaths from criminal abortion with infection are not included in the rate for 1933 but are included for 1943.

The decline in deaths from infection is probably associated with the advent of chemotherapy, the increased use of blood transfusions, the trend away from operative delivery, and better hospital regulations for asepsis.

The decrease in death rate from toxemia is undoubtedly the result of better prenatal care, with especial emphasis on better diet, and of the trend away from operative delivery of patients with eclampsia.

1942-43 — The more detailed classification of maternal deaths for 1942 and 1943, made possible by the 1939 revision of the International List, is shown in table 5. Using this classification it is possible to classify more of the deaths in the three major groups—infection; toxemia; hemorrhage, trauma, or shock. Table 5 shows that in 1943

TABLE 4.—MATERNAL MORTALITY BY AGE; UNITED STATES, 1933 AND 1943

Age at death	1943			1933			Percent change 1933–43
	Maternal deaths per 10,000 live births	Maternal deaths	Live births	Matrenal deaths per 10,000 live births	Maternal deaths	Live births	
Total..................	24.5	7,197	2,934,860	61.9	12,885	2,081,232	—60.4
10–14 years..................	99.0	37	3,737	137.9	37	2,684	—28.2
15–19 years..................	21.7	747	343,550	57.4	1,441	251,131	—62.2
20–24 yeara..................	15.8	1,473	930,015	42.6	2,646	620,418	—62.9
25–29 years..................	19.3	1,589	822,249	51.0	2,753	539,606	—62.2
30–34 years..................	29.9	1,528	510,413	72.9	2,578	353,495	—59.0
35–39 years..................	51.0	1,268	248,870	106.4	2,324	218,411	—52.1
40–44 years..................	74.2	493	66,406	124.8	952	76,261	—40.5
45 years and over.............	107.6	54	5,020	179.5	135	7,522	—40.1
Age unknown..................	17.4	8	4,600	16.2	19	11,704	+ 7.4

TABLE 5.—MATERNAL DEATHS FROM EACH CAUSE, BY TIME OF DEATH; UNITED STATES, 1943 AND 1942

Cause of death	Number of maternal deaths									
	Total		During or after ectopic pregnancy		During or after abortion[1]		Before delivery[2]		During or after childbirth[3]	
	1943	1942	1943	1942	1943	1942	1943	1942	1943	1942
All causes........................	7,197	7,267	332	346	1,165	1,231	1,022	1,110	4,678	4,580
Infection........................	2,593	2,808	62	76	789	929	179	190	1,563	1,613
Toxemias........................	1,936	1,866	—	—	110	79	690	777	1,136	1,010
Eclampsia........................	983	969	—	—	—	—	347	384	636	585
Albuminuria and nephritis...........	446	437	—	—	—	—	158	184	288	253
Other toxemias........................	507	460	—	—	110	79	185	209	212	172
Hemorrhage, trauma, or shock............	1,991	2,018	270	270	113	111	65	61	1,543	1,576
Other and unspecified causes............	677	575	—	—	153	112	88	82	436	381

[1] Abortion: Termination of a uterine pregnancy prior to 7 lunar months (28 weeks) of gestation.
[2] Deaths before delivery: Deaths of all women who died undelivered during uterine pregnancy.
[3] Childbirth: Termination of a uterine pregnancy at 7 lunar months (28 weeks) or more of gestation.

2,593 (36 percent) of the 7,197 maternal deaths were due to infection; 1,991 (28 percent) to the group of causes, hemorrhage, trauma, or shock; 1,936 (27 percent) to toxemia; and 677 (9 percent) to other and unspecified causes. The proportion in each cause group for 1943 was very similar to that for 1942.

Death rates from infection decreased proportionately more between 1942 and 1943 than those from any other cause group, as is shown in the following comparison:

Maternal Deaths per 10,000 Live Births

	All causes	*Infection*	*Toxemia*	*Hemorrhage, trauma, or shock*	*Other and unspecified causes*
1942....	25.9	10.0	6.6	7.2	2.0
1943....	24.5	8.8	6.6	6.8	2.3
Percent change	*—5*	*—12*	*0*	*—6*	*+15*

In 1943 the majority of the maternal deaths occurred during or after childbirth — 4,678 deaths or 65 percent of the total. During or after abortion there were 1,165 deaths (16 percent); 1,022 deaths (14 percent) occurred before delivevry; and 332 (5 percent) during or after ectopic pregnancy.

The following comparison shows that the greatest proportionate decrease in the maternal mortality rates between 1942 and 1943 in respect to time of death was for deaths occurring before delivery.

Maternal Deaths per 10,000 Live Births

	During or after ectopic pregnancy	*During or after abortion*	*Before delivery*	*During or after childbirth*
1942....	1.2	4.4	4.0	16.3
1943....	1.1	4.0	3.5	15.9
Percent change	*—8*	*—9*	*—13*	*—2*

Maternal mortality by States

In 1933 Florida had the highest maternal mortality rate, 115 per 10,000 live births; and Idaho the lowest, 43. In 1943 the State with the highest rate (New Mexico, 47) was not much above the one with the lowest rate in 1933, and two States (Oregon and Minnesota) had rates below 15.

In 1933 half the States had rates higher than 58.8 per 10,000 live births and half had rates lower than that. In 1943 the median rate was 22.5 per 10,000 live births.

Every State showed marked reduction in its maternal mortality rate during the 10-year period. The smallest reduction was 41 percent for North Dakota and the largest was 76 percent for Nevada.

In the last 2 years of the decade, the maternal mortality rate for the United States dropped 5 percent, but in those same 2 years it rose for 14 States. (Table 6.) Most of these 14 States have small numbers of maternal deaths in a single year, and therefore the rates are greatly affected by chance variations. A few of the 14 States, however, have comparatively large numbers of maternal deaths (California and Ohio for example) so that the increased rate in those States may mean an actual increase in the risk of dying from causes associated with childbirth.

Possibility of future reduction in maternal mortality

Gratifying as is the reduction in maternal mortality, the fact that more than half the States in 1943 had maternal mortality rates lower than the average for the country as a whole indicates that further reduction is possible. Although the States differ so widely in such population factors as race and age, in economic conditions, and in availability of medical care that it probably will not be possible for all States to reduce their rates to the level that was lowest in 1943, nevertheless advancements in medical knowledge would lead one to expect further reductions for the United States as a whole.

At the Conference on Better Care for Mothers and Babies, held in 1938, data were presented indicating that the maternal death rate might be reduced one-half to two-thirds.[3]

These estimates were based on various special studies of maternal deaths which had been made at different times from 1930 to 1935.

Additional data published in the proceedings of this conference showed that the reduction in the death rate from toxemia was greater than that from the other major cause groups. But in a few years, the death rate from infection showed a greater reduction than any other group.

The fact that the maternal mortality rate was reduced 60 percent in the 10 years from 1933 to 1943, practically substantiates the 1938 prognostication of a two-thirds reduction.

The fact that the goal set several years ago has been so nearly reached does not mean that further reduction is impossible. The fact that the rate for Negro women in 1943 was more than twice that of white women should point to ways of further reducing the total maternal mortality. If in 1943 the maternal mortality rate for Negroes had been reduced by a half but the number of both white and Negro births and the mortality rate for whites had remained unchanged, the rate for both races would be reduced more than 10 percent.

INFANT MORTALITY

In 1933 a total of 120,887 infants died before their first birthday. In 1943 the number dropped to 118,484 in spite of the increased number of infants born in the later year.

The infant mortality rate dropped from 58 to 40 per 1,000 live births—a percent change of 31, as is shown in the following comparison:

Infant Deaths per 1,000 Live Births

	Total	*White*	*Negro*	*Other*
1933......	58.1	52.8	85.4	127.5
1943......	40.4	37.5	61.5	84.6
Percent change..	*—30.5*	*—29.0*	*—28.0*	*—33.6*

This reduction, although not so great as the reduction in maternal mortality rate, nevertheless represents a real improvement and is not due to chance variations.

For this 10-year period the percentage reduction in mortality rates has been about the same for white and Negro infants, but during the last 2 years of the decade the infant mortality, like the maternal mortality, has declined proportionately more for Negro infants than for white infants.[4] The amount of change for each race is as follows:

Percent Change in Infant Mortality Rates

	1941–42	*1942–43*
Total	—11	0
White	—10	+ 1
Negro	—13	— 4
Other	—17	+14

Age at death

More infants died during the first month of life in 1943 than in 1933 but because of the larger number of births in the later year, the neonatal mortality rate declined 27 percent during the 10-year period.

Until 1940 the rates for deaths during the first day of life had decreased very little, but in the last 2 years there has been a noticeable drop in this rate. This decrease in rate for the first day possibly is related to improved maternal health, since the largest proportion of the early infant deaths are due to prenatal and natal causes.

More of the infant deaths occurred in the first day of life in 1943 than in 1933 (29 percent in 1943 and 26 percent in 1933). Also, more of the infant deaths occurred during the first month of life in 1943 than in 1933 (61 percent in 1943 and 58 percent in 1933). The decreases in the rates for different ages at death are as follows:

Infant Deaths per 1,000 Live Births

	First year	*First month*	*First day*
1933	58.1	34.0	15.1
1943	40.4	24.7	11.6
Percent change	*—30.5*	*—27.4*	*—23.2*

Causes of infant death

Because of changes in the International List of Causes of Death and in the basic tabulations of causes of infant death published by the Bureau of the Census, the groupings of causes previously used by the Children's Bureau cannot now be followed exactly. It is possible, however, to make comparisons for the most important causes of infant death.

In 1933, 53 percent of the infant deaths were due to prenatal and natal causes; in 1943, 60 percent. The mortality rates, however, decreased for all the major cause groups, as is shown in the following comparison:

Infant Deaths per 1,000 Live Births

	Prenatal and natal causes	*Influenza and pneumonia*	*Dysentery, diarrhea and enteritis*	*Epidemic and other communicable diseases*
1933	30.6	9.4	6.0	2.3
1943	24.1	6.2	3.3	1.3
Percent change	*—21.2*	*—34.0*	*—45.0*	*—43.5*

Between 1933 and 1943 the greatest reduction was in the death rate for the dysentery, diarrhea and enteritis group (45 percent), although the rate for the group, epidemic and other communicable diseases, was reduced almost as much (44 percent). These diseases are the ones most easily affected by public-health measures, such as pure water and milk supplies, adequate sewage disposal, and immunization, and therefore would be expected to show marked decreases.

The reduction of 34 percent for influenza and pneumonia is undoubtedly the result of the use of sulfa drugs.

The numerically largest group, prenatal and natal causes, showed a reduction in the mortality rate of 21 percent although this was a smaller gain than was shown by the other groups of diseases.

In 1943 there were 5,000 more infant deaths than in 1942, but because of the larger number of births the rates for the 2 years were the same, 40.4 per 1,000 live births. The prenatal and natal causes showed a slight drop (3 percent) in mortality rate. The other specific causes were higher in 1943 than in 1942. (Table 7.)

Infant mortality by States

In 1933 New Mexico had the highest infant mortality rate (136.1) and Washington the lowest (38.8). In 1943 New Mexico still had the highest rate but it had dropped to 91.6, a reduction of almost one-third. The lowest rate in 1943 was for Connecticut—29.8. In 1933 half the States had rates above 55.4 and half below that figure; in 1943 the point which divided the States equally was 39.6 per 1,000 live births. Every State showed a reduction in

Table 6.—Maternal mortality; United States and each State, 1943 and 1942[1]

Area	1943		1942	
	Number of maternal deaths	Rate (deaths per 10,000 live births)	Number of maternal deaths	Rate (deaths per 10,000 live births)
United States	7,197	24.5	7,267	25.9
Alabama	260	33.5	235	33.0
Arizona	38	26.6	49	38.7
Arkansas	168	39.4	158	37.0
California	357	20.5	306	19.8
Colorado	63	25.9	44	18.7
Connecticut	63	16.2	67	18.0
Delaware	15	24.1	9	15.9
District of Columbia	35	21.8	41	27.0
Florida	173	37.0	166	40.6
Georgia	307	39.2	300	41.4
Idaho	29	23.4	30	26.2
Illinois	320	20.5	326	20.9
Indiana	149	20.0	178	24.2
Iowa	80	16.8	94	19.4
Kansas	77	21.4	88	25.9
Kentucky	163	24.9	178	26.9
Louisiana	199	32.1	201	34.6
Maine	42	22.2	38	21.4
Maryland	85	17.9	88	19.9
Massachusetts	173	20.1	174	21.0
Michigan	226	18.0	257	20.7
Minnesota	84	14.4	96	16.3
Mississippi	236	39.4	249	43.9
Missouri	183	25.3	182	25.7
Montana	20	17.5	26	22.2
Nebraska	42	16.8	45	19.0
Nevada	6	19.8	2	7.2
New Hampshire	25	26.7	11	12.0
New Jersey	161	19.4	162	19.8
New Mexico	71	46.7	68	48.1
New York	521	21.0	545	22.3
North Carolina	306	32.4	307	34.2
North Dakota	39	29.1	29	21.7
Ohio	324	22.5	300	20.8
Oklahoma	122	25.1	142	30.9
Oregon	38	14.9	38	16.9
Pennsylvania	493	24.7	530	26.9
Rhode Island	33	22.5	26	18.3
South Carolina	240	44.3	260	53.2
South Dakota	20	15.6	25	20.1
Tennessee	204	29.1	197	30.2
Texas	420	25.5	440	30.4
Utah	27	15.7	27	17.1
Vermont	16	21.9	15	20.9
Virginia	210	29.1	220	32.4
Washington	72	16.2	68	17.4
West Virginia	126	29.1	103	23.5
Wisconsin	127	19.7	114	17.8
Wyoming	9	15.5	13	23.4

[1] Tabulations are by place of residence of deceased.

infant mortality rates during the 10-year period. The greatest reduction was for North Dakota (42 percent). The least reduction was shown by Washington (10 percent), which had the lowest rate in 1933.

The infant mortality rate, unadjusted for the changing number of births, was the same, 40.4 per 1,000 live births, for 1942 and 1943. For 21 States the rate was higher in 1943 than in 1942. New Hampshire showed the highest percentage increase, 28 percent. The largest decrease was 18 percent, for Wyoming. (Table 8.)

Possibility of further reduction in infant mortality

Although it may not be possible to reduce the infant mortality rate for the country as a whole to the low rate of 30 per 1,000 live births attained by 2 States in 1943, certainly the fact that 23 States showed rates above the national rate would indicate that some reduction is possible.

The goal of reducing neonatal deaths by a half, which was suggested in the 1930's, was not reached during this 10-year period.

The most important single cause of death is premature birth. Better prenatal care of mothers should reduce the number of infants prematurely born and better care of prematurely born infants should reduce the number of infants dying from this cause.

TABLE 7.—CAUSES OF DEATH IN THE FIRST YEAR OF LIFE; UNITED STATES, 1943 AND 1942

Cause of death	Deaths in the first year of life			
	Number		Number per 1,000 live births	
	1943	1942	1943	1942
All causes	118,484	113,492	40.4	40.4
Prenatal and natal causes	70,680	69,918	24.1	24.9
Premature birth	34,563	34,504	11.8	12.3
Congenital malformations	14,435	13,672	4.9	4.9
Injury at birth	10,990	11,455	3.7	4.1
Congenital debility	2,738	2,738	0.9	0.9
Other diseases peculiar to the first year of life	7,215	6,704	2.5	2.4
Syphilis	739	845	0.3	0.3
Influenza and pneumonia	18,207	16,144	6.2	5.7
Dysentery, diarrhea and enteritis	9,756	8,694	3.3	3.1
Epidemic and other communicable diseases[1]	3,685	2,952	1.3	1.1
All other definite causes	11,178	10,527	3.8	3.7
Ill-defined and unknown causes	4,978	5,257	1.7	1.9

[1] Measles, scarlet fever, whooping cough, diphtheria, cerebrospinal (menin-ococcus) meningitis, and tuberculosis.

TABLE 8.—INFANT MORTALITY; UNITED STATES AND EACH STATE, 1943 AND 1942[1]

Area	1943		1942	
	Number of infant deaths[2]	Rate (deaths per 1,000 live births)	Number of infant deaths[2]	Rate (deaths per 1,000 live births)
United States	118,484	40.4	113,492	40.4
Alabama	3,477	44.8	3,561	50.1
Arizona	1,097	76.7	1,014	80.1
Arkansas	1 594	37.4	1,694	39.7
California	5,999	34.4	5,385	34.8
Colorado	1,228	50.4	1,172	49.7
Connecticut	1,162	29.8	1,088	29.2
Delaware	291	46.7	266	47.0
District of Columbia	765	47.6	771	50.8
Florida	2,181	46.7	1,953	47.7
Georgia	3,656	46.6	3,571	49.3
Idaho	396	32.0	415	36.2
Illinois	5,184	33.3	5,170	33.1
Indiana	2,960	39.6	2,701	36.6
Iowa	1,618	34.0	1,623	33.5
Kansas	1,212	33.6	1,205	35.5
Kentucky	3,280	50.0	3,209	48.4
Louisiana	2,773	44.7	2,802	48.2
Maine	972	51.3	816	46.1
Maryland	2,037	43.0	1,941	43.9
Massachusetts	2,939	34.2	2,651	32.0
Michigan	4,813	38.3	4,608	37.2
Minnesota	1,809	30.9	1,739	29.6
Mississippi	2,800	46.8	2,680	47.3
Missouri	2,918	40.3	2,761	39.0
Montana	442	38.7	395	33.7
Nebraska	889	35.5	791	33.4
Nevada	158	52.2	159	57.2
New Hampshire	432	46.1	329	35.9
New Jersey	2,796	33.7	2,542	31.1
New Mexico	1,394	91.6	1,383	97.9
New York	8,126	32.7	7,814	31.9
North Carolina	4,416	46.7	4,342	48.3
North Dakota	468	34.9	488	36.5
Ohio	5,640	39.1	5,345	37.0
Oklahoma	2,068	42.5	1,906	41.4
Oregon	763	30.0	687	30.5
Pennsylvania	7,551	37.9	7,527	38.2
Rhode Island	638	43.5	560	39.5
South Carolina	2,985	55.1	2,866	58.7
South Dakota	457	35.7	474	38.2
Tennessee	3,143	44.8	3,020	46.4
Texas	8,454	51.4	7,760	53.6
Utah	539	31.4	522	33.0
Vermont	285	39.0	299	41.7
Virginia	3,395	47.1	3,565	52.5
Washington	1,550	34.8	1,292	33.1
West Virginia	2,261	52.1	2,329	53.0
Wisconsin	2,257	35.0	2,050	32.0
Wyoming	216	37.1	251	45.1

[1] Tabulations are by place of residence.
[2] Deaths under 1 year, exclusive of stillbirths.

A limited supply of reprints of this article will be available from the Children's Bureau, Washington 25, D. C.

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[1] For a discussion of the problem of classification of causes of death, see Vital Statistics Rates in the U. S., 1900-1940, by Forest E. Linder and Robert D. Grove (U. S. Bureau of the Census, Washington, 1943).

[2] Yerushalmy, Jacob, Carroll E. Palmer, and Morton Kramer. Studies in Childbirth Mortality II. Age and parity as factors in puerperal fatality. Public Health Reports, Vol. 55, No. 27 (July 5, 1940), pp. 1195-1220.

Deaths from Puerperal Causes by Race and by State; United States, 1943. Bureau of the Census, Vital Statistics Special Reports, Vol 21, No. 5.

[3] Proceedings of Conference on Better Care for Mothers and Babies, Washington, D. C., Jan. 17-18, 1938, p. 146. Children's Bureau Publication No. 246.

[4] The rapid changes in the birth rates during 1942 and 1943 have not been considered in the calculation of the infant mortality rates used here. For discussion of this factor see "Effect of Changing Birth Rates Upon Infant Mortality Rates," by Iwao M. Moriyama and Thomas N. E. Greville, in Vital Statistics—Special Reports, Vol. 19, No. 21 (Bureau of the Census, Department of Commerce, Washington), and the very brief note in "Maternal and Infant Mortality in the U. S., 1942," by Marjorie Gooch, *The Child*, Vol. 8, pp. 179–185 (June 1944).

CHILDREN AROUND THE WORLD

FRANCE

Legislation on juvenile delinquency

The alarming increase in juvenile delinquency in France in the years 1940-1944 has impelled the Provisional Government of that country to take new measures for dealing with the problem. A special procedure was introduced by a law of 1942 for hearing cases of young persons accused of illegal acts; and penalties were replaced by educational or corrective measures. This law was considered satisfactory in the beginning, but its defects, gradually discovered during the 30 years of its administration, and the recent progress in psychology and child training have shown the need for better methods of treating juvenile delinquency. To bring about such an improvement is the aim of a decree of February 2, 1945.

Juvenile courts under the decree of February 2, 1945

Under the law of 1912 children's cases were heard in courts of first instance, in addition to those of adults, but separately from them. The new decree provides for a separate juvenile court in each court of first instance. Each juvenile court is to be presided over by a "children's judge" selected from among the judges of the court of first instance and appointed for 3 years. The children's judge is to be assisted in hearing cases by two men or women active in child-welfare work, called assessors. These also are appointed for 3 years. Two substitute assessors must also be attached to the court.

Juvenile courts with a large number of cases may have two or more judges. The juvenile court in Paris, which also serves the surrounding territory of the Department of the Seine and to which are referred more than one-half of the cases of juvenile delinquency in the whole of France, is to have a presiding judge and a vice-president.

Field of jurisdiction of the juvenile court

As under the old law, the special methods prescribed by the decree of 1945 for treating juvenile delinquency apply to persons under 18 years of age accused of crimes or misdemeanors. Protective, educational, or corrective measures alone are permitted; penalties are applicable only in exceptional cases.

Procedure

In order to simplify procedure the present decree authorizes the children's judge to investigate cases of apparently minor offenses. The judge may decide alone in such a case, without referring to the juvenile court as a whole. During such an investigation the child is to be placed in an observation center instead of a police detention station, as was the custom in the past.

The judge may also order an investigation in any other case. The investigation is to include a study of the child's personality, the record of his school attendance, a physical and a psychological examination, and information about his family. The investigation is to be made preferably by trained social workers.

Before deciding on a case, the court hears the child, his parents or guardian, other witnesses, the public prosecutor, and the defense attorney. The child may be excused from appearing in court; he is then represented by his father, mother, or guardian, or by a lawyer.

The hearings and discussions at the court are closed to the general public, and publication in books, the press, motion pictures, the radio, or in any other way is prohibited. Fines are prescribed for violations of this provision.

If the court decides that the child has committed no punishable act, it dismisses the case. Otherwise, it may take any of the following measures:

1. Admonish the child;
2. Return the child to his parents, guardian, or other person who had been caring for him;
3. Place the child with a suitable family or individual, in a public or private welfare agency, or in an institution, whether educational, medico-educational, or one for vocational training, or for general care.

Probation

Probation is now given a more important place than heretofore. Whereas the law of 1912 made no mention of trained social workers serving as salaried probation officers, the present decree provides for the employment of such workers and for the regulation of their employment. As heretofore, the employment of volunteers is permitted; but experience in child welfare is emphasized. All persons engaged in probation and attached to one court are to work under the direction of a trained probation officer.

In the cases in which the court prescribes protective, educational, or rehabilitation measures, it may order probation as a supplementary measure, to be continued not later than the date on which the young person reaches the age of 21.

The probation officer is required to report to the judge the progress of the case, particularly any difficulties that may arise in the young person's conduct or environment; he may also suggest changes in the care of the child. Lack of proper supervision by a parent or guardian is punishable by a fine.

One year after the child has been removed from his family by court decision, the parents, guardian, or the child himself may ask for his return to the family; the request must be accompanied by evidence of the parents' or guardian's ability to take proper care of the child and of sufficient improvement on the part of the child.

Every person, agency, or institution offering to care regularly for children or young persons in compliance with the present decree must receive permission from the prefect of the department (administrative division of the French territory). Conditions to be specified in a subsequent decree must be met in order to receive this permission.

Source: *Journal Officiel de la République Française, February* 4, 1945.

Anna Kalet Smith

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DECEMBER 1945

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The CHILD

CHILDREN'S BUREAU • U. S. DEPARTMENT OF LABOR

Feb. 7, 1946.

- I. L. O. ACTS IN BEHALF OF YOUTH
- NEGRO YOUTH'S DILEMMA
- HANDICAPPED CHILDREN IN CAMP

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The CHILD

MONTHLY BULLETIN

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The picture on the cover, showing mothers receiving bottles of cod-liver oil and concentrated orange juice at a municipal medical center and day nursery in London, is a British official photograph.

U. S. DEPARTMENT OF LABOR
L. B. SCHWELLENBACH, *Secretary*

CHILDREN'S BUREAU
KATHARINE F. LENROOT, *Chief*

CHILDREN AND THE WORLD'S FOOD

You ask me "What is the meaning for children of the Food and Agriculture Organization of the United Nations?"

To put it in the broadest terms, I would say that such international agencies as the FAO, fostering day-by-day cooperation among all peoples for the things they all need and want and believe in, are the practical alternative to armed aloofness among nations. If we choose the one, it will mean life and hope and the chance of happiness for the children of this generation. The other will usher in for them the era of dreadful night, dominated by the constant threat of atomic obliteration.

Or let me put it this way. Science itself is the atomic bomb, and we are hitched to its tail. We can use science for death or for life, but it must be plain by now that we cannot use it a little for one and a little for the other. The forces it commands are so powerful that if we continue to use them for the purposes of death, we shall end by destroying both science and ourselves.

To break old deathward-turning institutions and habits will require a decisive, world-wide turning toward life. FAO is such a lifeward turn. It is founded on the belief that the world's accumulated and steadily growing scientific knowledge can be mobilized—must be mobilized—not to bring death on an unprecedented scale to mankind, but to bring an unprecedented abundance of life.

Forty-two nations established the FAO in a conference at Quebec in October. The delegates unanimously named Sir John Boyd Orr as the first Director-General of this, the first of the new, permanent United Nations organizations.

Great numbers of children, especially in those countries where there is much poverty, start life as underfed waifs. They are destined to die young, victims of tuberculosis, anemia, pellagra, rickets, and the other diseases that thrive wherever hunger is widespread. Yet elsewhere, quantities of food that would mean life and health to these children may be rotting unharvested for lack of paying markets.

John Orr has a deep and driving conviction that in the modern world of scientific achievement these things must not be. Not only can famine and starvation be eliminated from the earth; enough food can be produced to bring every man, woman, and child up to a decent health standard.

It will be an immense and intricate undertaking, not to be accomplished overnight, not to be accomplished at all without the kind of international cooperation that is made possible by the FAO.

John Orr is not alone in his convictions and views regarding the possibilities inherent in the widespread application of science in agriculture, forestry, fisheries, and nutrition. They are shared by many men and women all over the world today. They were expressed in the recommendations of the Hot Springs Conference where FAO was conceived and reaffirmed at the Quebec conference where it was born. But John Orr personifies these convictions perhaps better than any other one man, and under his leadership FAO will move vigorously toward realizing them.

Between Hot Springs and Quebec occurred the atomic bomb. The lifeward turn represented by such organizations as FAO came none too soon. The time is short: there is little margin now for the unforeseen and the accidental. For the sake of children especially, FAO must be successful from the beginning. It needs the understanding and support of men and women everywhere.

Gove Hambidge

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I. L. O. ACTS IN BEHALF OF YOUTH

Problems of children and young workers get special attention from delegates of 48 nations

by ***KATHARINE F. LENROOT,*** ***Chief, Children's Bureau***

AGAINST a background of war and destruction, and amidst the stirrings of reconstruction, representatives of Governments, employers, and workers of 48 nations assembled in Paris October 15 for the twenty-seventh session of the International Labor Conference. Created after the first World War, the International Labor Organization was established on the principle that lasting peace could be founded only on social justice. Its vitality and record of solid achievement make it one of the most important international instruments of the present postwar era.

An American who has not before visited war-torn Europe can fully measure the depth of the impression made only on her return, when she sees here the streets full of automobiles, the people well-clothed and well-fed, the shops and markets full of goods at prices which bear at least some measurable relation to prewar levels, and knows that everywhere in the country homes and buildings are intact, streets brilliantly lighted, and houses warmed. Even after a short absence one feels a sense of unreality about the security which has saved our mainland shores from attack and destruction through two world wars, but which will not again protect us should we and our allies fail to take measures to make a third cataclysm impossible. The only way in which we can share in the spiritual rebuilding of peoples arising from the ashes of destruction, as we shared in the battles which brought victory to the free nations, is to make their cause our own and give of our plenty in the utmost measure.

The work of the Conference centered upon four main subjects: maintenance of high levels of employment; protection of children and young workers; minimum standards of social policy in dependent territories; and constitutional questions relating to the structure and functioning of the International Labor Organization and the ways in which it may be brought into relation with the United Nations Organization.

It is significant indeed that the problems of children and youth should have been given so prominent a place in the work of this first postwar International Labor Conference. Their needs and measures necessary to assure adequate protection were considered in a tripartite committee of representatives of governments, employers, and workers, which held 22 sessions and presented two reports to the Conference in plenary session.

As is customary, the Director's report and speeches commenting upon it gave opportunity for bringing general matters before the Conference. This year delegates from European countries were asked particularly to describe briefly the general conditions in their own countries. Their statements of loss, suffering, deprivation, and courageous determination to rebuild were unforgettable.

HUNDREDS OF THOUSANDS of Europe's children will die this winter of cold, hunger, unless we get help to them.

Photograph by UNRRA

Cold, hunger, tuberculosis, and separation of families through deportations for forced labor in Germany, service in the armed forces and in the resistance movement, all have had serious effects upon children and young persons in all the occupied countries. In Belgium, one-sixth of the working population had been deported to Germany or, in lesser numbers, to occupied France, for forced labor. From Poland, the Minister of Labor and Social Welfare reported that of the 7 million children under the age of 14 years, 650,000 are full orphans; 300,000 had been forcibly abandoned by their parents, most of whom had been placed in concentration camps or taken for conscript labor; 1,000,000 are half-orphans; and 2,000,000 more have to be clothed and fed because their parents are too impoverished to care for them. There are 1,000,000 homeless persons, about 300,000 of whom "are compelled to occupy holes dug in the earth. Some of them have neither clothing nor even shoes." In personal conversation the speaker said, "Our people can stand being without food; they are used to it. But they can't stand being without clothing in the winter cold."

The Government delegate from Italy reported that Italian towns, large and small, are largely in ruins, and that eight and a half million people have no roof to cover them during the coming winter. Very few schools are left, most of them having been destroyed or requisitioned for other purposes. In the Netherlands, though progress has been made since liberation, the food supply is still scanty. There is an appalling shortage of clothes, shoes, and other necessities. People in many districts are living in cellars

(Footnote: Miss Lenroot attended the I. L. O. Conference as an official adviser to the delegates for the Government of the United States of America.)

or barns. Infant mortality is at a high level. In France, information brought to the writer's attention indicated that the weights of children at birth are down 200 to 300 grams and infant mortality has increased. Adolescent children present grave problems of malnutrition and tuberculosis. Clothing, fuel, and food are seriously short. Juvenile delinquency is causing great concern.

The Committee on Protection of Children and Young Workers met under the chairmanship of Mr. Leon Eli Troclet, Minister of Labor and Social Welfare of Belgium. Mr. David Zellerbach, employers' member for the United States of America, and Miss Florence Hancock, workers' member of the United Kingdom of Great Britain and Northern Ireland, were vice-chairmen. The writer and Mrs. Alva Myrdal, Swedish Government member, served as reporters and presented the work of the committee to the plenary session of the Conference. Many of the 56 members of the committee (24 government members, 16 employers' members, and 16 workers' members) had come from countries recently liberated from enemy occupation. They brought to the committee their deep conviction that the protection and welfare of children and young persons are matters of the most urgent importance, and must be given priority in plans for social reconstruction.

The first part of the committee's work dealt with proposed lists of points for consultation with governments, preparatory to next year's conference when draft conventions will be drawn up for presentation to member governments for ratification. The subjects discussed were medical examinations for fitness for employment and restriction of night work, both relating to children and young persons.

It was proposed that the medical examination convention cover both industrial and nonindustrial occupations, and that the night-work convention cover nonindustrial undertakings, since industrial undertakings had already been covered in the night-work convention of 1919. It was pointed out that young agricultural workers also need the protection of medical examinations.

A resolution was adopted recommending that the staff of the I. L. O., in consultation with the Permanent Committee on Agriculture, undertake a study of the possibility of extending the protection of medical examinations for fitness for employment to children and young persons engaged in agricultural occupations. Another resolution adopted by the committee requested the Governing Body to examine the possibility of revision of the 1919 convention on night work for young persons in industrial occupations.

Employers, workers, and government members were all in general agreement on the importance of medical examinations and restriction of night work. The report of the committee, containing revised lists of points for consultation and the two resolutions noted above, was adopted unanimously by the Conference, and the Governing Body later placed these matters on the agenda of next year's International Labor Conference, which will meet in Montreal.

Twelve meetings of the committee were devoted to a draft resolution on the protection of children and young workers and another on youth of liberated countries. The text of the first resolution, proposed by the Office, had been prepared after consultation with a group of experts from some 12 countries, which met in Montreal last spring. It aimed to present a coordinated scheme of various measures for the realization of the essential objectives of the International Labor Organization on the protection of youth, formulated in its constitution and in the Declaration of Philadelphia. In the words of the report of the committee to the Conference, "It amalgamates the many decisions already formulated by the Conference in the form of conventions and recommendations, and suggests supplementary standards on questions which have not yet been studied by the Conference." A representative of the Conference of Allied Ministers of Education attended the sessions of the committee and collaborated in its work.

During the general discussion of the resolution, many employers', workers', and government members of the committee gave their warm approval to the broad outlines of the plan and expressed the hope that the resolution might become an instrument of progress even though for some countries certain of the standards proposed constitute an objective that can only be realized step by step. They thought such a plan might stimulate interest in these problems and encourage collaboration between all the administrations concerned.

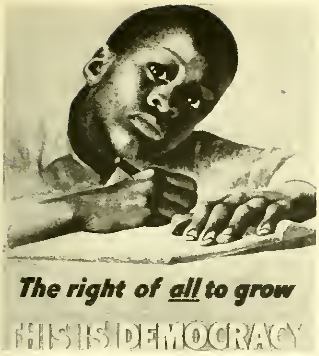
Included in the resolution are sections on:

General Social Protection, including maintenance, health, and social protection; Educational Opportunities; Admission to Employment; Protection of Young Workers; Administration of Protective Policies; and Collaboration on an International Basis. Discussions of the subjects of hours of work and wages gave rise to the adoption of compromise texts concerning which certain reservations were made. The resolution as amended was adopted by the committee without opposition, though with certain reservations, and was in turn adopted by the whole Conference without a negative vote. The text should receive careful study by all concerned with the protection of our own children and young persons and the development of international standards.

The draft resolution concerning the youth of liberated countries, with minor amendments, received the unanimous approval of the committee and the Conference. It calls for giving full material and moral support in the task of reconstruction by all nations which are able to do so, and in particular by those which have escaped the ordeal of occupation by the enemy.

Two other resolutions were adopted: One requests the Governing Body to place on the agenda of an early—if possible the next—session of the International Labor Conference the question of regulating the underground work of young persons in mines. The other requests the Governing Body to set up an advisory committee for studying the problems of young workers.

A limited supply of reprints of this article will be available from the Children's Bureau, Washington 25, D. C.


The right of all to grow
THIS IS DEMOCRACY

Poster by Ben Shahn

An eminent sociologist discusses the plight of children without an accepted past or future

NEGRO YOUTH'S DILEMMA

by CHARLES S. JOHNSON, Ph.D.,

Director, Department of Social Science, Fisk University

THE CORE of the present problem of Negro youth is that they lack a stable tradition in harmony with the culture to which they are being assimilated, and they have no well-defined future toward which their drives might be fashioned.

They belong to a people who here in America have been and are essentially in a state of transition and change; and the result is a strange and persistent conflict between inescapable folk traditions which underlie their life and the whole American culture which they theoretically inherit, along with other Americans. It is a culture, however, that makes no provision for their complete integration within its main stream.

This conflict, as it affects the development of the Negro child, is clearly seen in the schools. Contrast the content of common-school instruction, which is the formal medium of communicating culture, with the incongruous pattern of life of many of the Negro children themselves. The school should relate a child to his ongoing past and provide him with the manual and intellectual tools for dealing with his environment. But the Negro child in the dilapidated, ill-equipped, and ill-taught rural school finds little that he can relate to the way in which he is going to earn his living, to his own family or community environment, or to his own experience of life. The teacher herself rarely understands the stresses of the culture in which she and her pupils are both involved.

Reflecting this purposelessness are findings of a recent study made of Negro youth in the rural schools. More than half of the young people covered, the study disclosed, are uninterested in school; most of them view American and European history as unrelated to their own past or future careers; they lack the psychological set and self-confidence for using numbers; they read poorly and without a will to translate the printed page into familiar experiences; they lack the elements of precision and exactness in manual manipulation; and in general make little or no connection between school and everyday life.

The school is either casually accepted for its social satisfactions without serious regard for the subject matter presented, or it is expected to provide a formula for escape from a status: for those who remain beyond the seventh grade the only useful function of the elementary rural school is to prepare the pupils for high school, and the high school, in turn, makes it possible for a very few to go to college. The only convincing value of intelligence tests given under such circumstances is that they perhaps provide an index of the detachment of the average Negro youth from the significant currents of knowledge in the dominant culture. In a test made of 2,250 Negro youth the boys had a median intelligence quotient of 77.5; the girls, 79.6; but this no more means that these youth lacked native ability than that the girls were basically more intelligent than the boys. The sex difference may possibly mean only that the girls accepted with greater docility the unrealistic instruction meted out to them.

Consider, too, the conflict set up in the Negro youth through his unconscious absorption of the value judgments of the white world on Negro physical traits, notably color. The extent of racial mixture in the Negro population makes this an important problem in personality adjustment. "Blacks" in this ideological heritage, have a pronounced disadvantage. For example, a group of Negro youth was asked to check the color of the ugliest boy or girl each knew: 40 percent checked "black," as contrasted with 10.8 percent who checked "yellow," and only 6.5 percent who checked "light brown." That "light brown" should be the ideal is significant.

The social values associated with color have extremely serious consequences for Negro youth. Conflict situations may develop even within families. It often happens that darker children feel that their parents give preference to the siblings of lighter complexions. Even such inadvertent and casual comparisons as "better hair," "nicer complexion," "prettier skin," "nicer shade" affect the more sensitive youth and contribute to their sense of inferiority. Children, in turn, may apply color values unfavorably to one or the other of their parents, or find themselves apologizing for the dark complexion of a parent. They may even harbor resentment against the person who was biologically responsible for their own undesirable appearance. By far the most frequent instances of color sensitivity, however, occur outside the home as the child attempts to make adjustments to new groups.

The tendency to put a low valuation on himself and his group is reinforced by both the instructional content and the daily experience of the Negro child in the school. To those in the inferior separate school, the school itself is a reminder. In mixed schools minority children are made to feel "different" or "inferior," and at the same time the children in the majority group absorb a corresponding attitude of superiority. Both results run counter to the grain of democracy and make it impossible for minority youth to contribute to American culture according to their native abilities.

Furthermore, minority children in mixed groups may meet these attitudes not only from their schoolmates, but also from their teachers; for the teachers too often not only share but also shape the unfavorable viewpoint of the students. There is, moreover, nothing of a compensatory nature in what the child reads that counteracts the perverted information the teacher metes out. What he finds in textbooks, what he reads for amusement, and what he sees at the movies all support the deliberately fostered opinion of his inferiority. In the history textbooks of 16 southern States, so the study showed, the Negro was depicted as a shiftless character or a fool, if worthy of mention at all; and it is well-known that many Southern cities deliberately ban moving pictures showing Negroes in other than the traditional light. However, materials commonly encountered by children in the North are not much better.

Besides all else with which the Negro child must contend in a world of "white" values, he has to make an adjustment to class differences within his own group. These distinctions are being slowly created, as differences in education, occupation, wealth, and, to some extent, length of family line operate to set one group apart—above or below the others (just as these differences operate to stratify society as a whole.) In the Negro group, these social distinctions are sources of emotional tension which find acute expression, notably in the adolescent period.

Poverty and ignorance confine the youth of the lowest economic classes in a low and loose cultural world. The hopelessness of their status often contributes to a type of free living that acknowledges little responsibility to accepted standards. With less opportunity for recognition through education, money, and status, the youth of these families more often seek their self-assurance in sex freedom; or in a reputation for physical prowess; or in being known as a bad man or in other antisocial forms of behavior. This observation does not, of course, apply to all youth of this class. Many are in families that are merely uneconomic units, incapable of self-support: they may be sensitive to community values, but nevertheless be forced to live only as conditions permit, whether or not their social behavior is approved.

For children in these low economic groups the adjustment is indeed difficult, but not the most difficult; for the higher the social classification of the Negro youth and the more intelligent the person, the more acute apparently are his adjustment problems. It is not possible for the youth of the upper classification to utilize the simple escapes that are possible for youth in families in which less is expected. Concern with class and status for him as for others so placed exercises a control over vocational interests; and whereas the middle-class Negro youth finds his tensions in the struggle to dissociate himself from the conspicuous status of the

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Photograph by FSA

Photograph by OWI

lower-class Negro youth and to achieve the exclusive status and apparent immunities of the upper class, the youth of the upper class, in his turn, finds that in his development he has reached the limits of racial tolerance. Having neither hope of attaining higher status, nor ncentive, he frequently lacks the educational zest of the middle-class youth, or for that matter, some of the lower-class youth.

Another large factor affecting the adjustment of the Negro youth is that he is likely to be a migrant himself, or else in a family that has wrenched itself out of a rural environment and implanted itself in a city, often in another section of the country.

Since the rural South offers to most Negroes little hope of satisfactory solutions for their problems, economic or social, there is a general desire to seek a solution by getting out of the environment altogether. The stream of migration never stops, but any strong economic force that offers an immediate way out of the practical problems involved, such as the wartime demand for workers in the North and West, strengthens and deepens its flow. It may be still further increased with the economic reorganization of cotton production, which is now taking place. These migrations are forcing upon the attention of the country as a whole the problems of the Negroes and their children, making it essential for members of Northern and Western communities to understand the forces that govern the behavior of these practically useful, but too often socially unwelcome, newcomers.

Migration, at least in times of labor scarcity, may solve the Negro's problem of making a living, but it may at the same time intensify his and his children's social disorganization and lack of adjustment to his environment. The "folk" Negroes who come into the city from isolated areas of the South and find employment in unskilled work or domestic service are conscious of their lack of experience. Not knowing how to participate in the new setting, they seek security in their former cultural organizations and tend to live in an extended isolation. Just as their ways of life and standards of living are only slightly altered by moving to the city, so their habits of thought are only slowly changed. They retain as far as possible the controls which governed them in the rural areas and ignore the legal and conventional demands made upon urban dwellers. As a result parents and children making up these migrant families often come to be regarded as problems to the community. In reality, though, these Negro migrants are not very different in character from other first-generation immigrants who, bewildered by the city, seek to retain organized personalities by recreating, in "pockets" of the city, the association institutions and customs with which they are familiar.

Strain within the family, meanwhile, may result from the fact that occupations in the city do not permit the constant association of parents and children, as was true on the farm. With both parents out of the house for long periods in the day the children are left to their own devices, and these may lead to antisocial behavior. The older children, on the other hand, may take jobs, either because it is necessary to supplement the income or because the chance to increase it easily overcomes the parents' as well as the young person's ideas about the value of education, ideas which are hazy at best. These jobs take the children into situations beyond the reach of parental control.

In these migrant families, the influence and prestige of the parents are often undermined by the child's awareness that he is more conversant with city ways than they are.

"In the case of a foreign-nationality group, the second or third generation ordinarily moves out of the slum areas into the suburbs or better residential parts of the city. In the case of Negroes, community practice largely prevents such natural adjustment by restricting them to congested and run-down areas, regardless of their economic ability..."

Photograph by Sekaer for National Housing Agency

Photograph by National Housing Agency

The persons who influence his opinions are not his parents, but those who are able to explain the city and its life to him, and acquaint him with new behavior patterns and advanced ideas. What he learns may be of doubtful value, but in his attempt to make an adjustment—even a bad one—the child has moved beyond his parents, whose "quaint" ideas and crude behavior certainly belong more to the farm than to city streets. When the parents lose prestige in the eyes of their children and the family becomes disorganized, the behavior of the children may become aimless, if not downright antisocial.

Problems such as these have often been noted in the children of immigrant parents, but as the alien group as a whole becomes adjusted to the new life and integrated with it, these conflicts have been, and are, resolved. But because there is not a general will to integrate the in-migrant Negroes fully into the life of the city, the situation for their children is not the same as for those of other in-migrant groups.

In the case of a foreign-nationality group, to cite an example of this difference, the second or third generation ordinarily moves out of the slum areas into the suburbs or better residential parts of the city. In the case of the Negroes, though, community practice largely prevents such natural adjustment: regardless of their economic ability to command better housing in a pleasanter neighborhood, the Negroes are restricted to congested and run-down areas. It is also natural, in the course of time, for a group which formerly provided largely unskilled workers to move up into the ranks of skilled labor, or to enter clerical occupations, or in some cases, the professions. The Negro group, though, except in unusual circumstances, is denied the opportunity. It is unreasonable, therefore, to expect that Negroes will make as satisfactory an adjustment to city life as those for whom these ultimate solutions are available to a reasonable degree, and their failure and frustration bear heavily upon their children, deepening their dilemma.

It is not only Negro youth and others in minority groups whose development is restricted and distorted by disadvantages and inequalities of opportunity. In varying degree, large numbers of the Nation's youth are being denied the possibility of developing to the limit of their capacities. I am speaking of inequalities arising out of differences other than race, or national origin, or whatever else sets a minority group apart; there are, besides, differences of economic status, of family circumstances, or of place of birth, differences that affect the whole population.

We cannot give to every American child an *equal* chance for a happy and a useful life. But our concept of democracy seems to require that we seek for every child a *reasonable* opportunity.

Progress toward this end demands first of all a level of employment high enough to provide a job at a decent wage for everyone who wants one and can fill one; it demands in the second place health programs broad enough and big enough to assure to every child the minimum essentials of medical care; and it demands in the third place that we translate into living practice our long-accepted theory that every child should receive an adequate education at public expense.

Experience, expert knowledge, and simple arithmetic all demonstrate that these ends cannot be achieved by leaving action entirely to individual States or communities, important as it is that local resources and experience should be fully engaged in the effort. We must realize that it is absolutely in line with our democratic tradition to do as a Nation and as a whole people what cannot be done piecemeal and State-by-State. If we accept this principle, and embark wholeheartedly on such a program, much will have been done to ensure for a future America stronger, better, happier young people.

But we must recognize that as regards the young people of minority groups two additional factors are involved. In the first place no program for youth in general will automatically reach the youth of these groups. Special care must be taken and special techniques instituted to make sure that funds appropriated for education, or for health, or for child-welfare programs are really administered according to need, and without regard to race, religion, or national origin. In the second place, no amount of education or medical care, nor even a reasonable opportunity to make a decent living, will solve for the Negro youth some of the problems arising out of his sense that he is unacceptable to the greater part of the society and culture into which he has been born, and in which he perforce must live.

We have the faith to believe that an honest facing of the present is the best guarantee of a wholesome and happy tomorrow. There is evidence of this facing of the present in the now-pending proposals to invest a part of our national wealth in the care of our children without discrimination on the basis of race or color or locality or place of origin. Our faith in our fundamental democracy is the only sure support of our faith in the future of our children. They are our tomorrow.

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This article is taken from an address by Dr. Johnson which was delivered recently to a group of State officials and representatives of State welfare organizations at the Kruse School, a training school for Negro girls, in Marshallton, Del., on the occasion of its twenty-fifth anniversary. Dr. Johnson spoke as a member of the National Commission on Children in Wartime, a group of outstanding men and women working in the fields of child health and child welfare, appointed by the Children's Bureau.

Head of the Department of Social Science at Fisk University in Nashville, Tenn., Dr. Johnson is also a director of the Julius Rosenwald Fund. He is the author of a number of books, among them *"The Negro in American Civilization," "Shadow of the Plantation," "Growing Up in the Black Belt,"* and *"Patterns of Negro Segregation."* He was one of those who worked with Dr. Gunnar Myrdal, the Swedish sociologist, whose study of Negroes in the United States, made for the Carnegie Foundation, was published in 1944, under the title, *"An American Dilemma."*

Suggestions on Unemployment Compensation for Young Workers Returning to School

As part of the movement to encourage young people to return to school if and when they are released from their wartime jobs, Ewan Clague, Director of the Bureau of Employment Security, Social Security Board, recently wrote a letter to the heads of the State employment-security agencies concerning questions on unemployment-compensation administration that were raised by the Back-to-School drive. Some of the suggestions made in this letter are quoted here.

"What employment-security agencies can do to further this drive differs from State to State. In a few States practically nothing can be done because their laws prevent payment of benefits to students. But in most States the laws permit wide discretion by the agencies in determining availability for work. In those States benefits may be paid to some students without straining accepted interpretations and principles.

"By no means are we suggesting that young people who do not want to work be considered available for work. There will be, however, many young people who want to work but whose prospects of immediate reemployment will be slight. If return to school results in denial of benefits, this group of workers may spend their time in idleness in order to draw benefits, rather than reembark on their school careers until such time as they can find jobs.

"From the point of view of the community as a whole, as well as that of the individuals concerned, it would be better for these young people to be in school rather than doing nothing, while they are trying to find jobs. In previous times, agencies have held that unemployed individuals could attend school and still be considered available for work, if they demonstrated that their school attendance would not hinder their prompt acceptance of suitable work. This was done before the war, when the labor-market situation was such that many workers might anticipate long periods of unemployment. It was also quite common during the days when workers were encouraged to take defense training courses for war industries. In many States, a worker who undertook such a course and stated that he was willing to take suitable work when it was offered was deemed available for work until such time as he actually refused a job. This is the principle which might be applied to child workers who return to school, so that they may be paid unemployment compensation if they certify that they are willing to accept work, until a time when suitable work has been offered and refused.

"A secondary method of furthering the campaign relates to part-time work. A number of State agencies have held during the war years that a worker who cannot take full-time work is unavailable for work regardless of the amount of part-time work he is able to accept. Many of these agencies, however, held before the war that those who were available for only part-time work were, nevertheless, "available" within the meaning of the law. Undoubtedly, many children who have worked during the war will desire to perform some work after school hours. The payment of benefits to those children seeking part-time work will encourage them to return to school. Naturally, if they refuse suitable part-time work without good cause, they should be disqualified."

Youth Employment on the Eve of V-E Day

Final stages of the war in Europe saw about the same level of employment of civilian workers 14 through 17 years of age as in the same period of the preceding year. In the week ended April 14, 1945, about a month before V-E Day, special information on youth employment was obtained by the Bureau of the Census by means of supplementary questions asked in its monthly sample survey of the labor force. This survey showed that about 3 million boys and girls 14 through 17—more than 30 percent of the civilian population in this age group—held civilian jobs. Almost a million of these workers were 14 or 15 years of age—nearly one-fifth of all youngsters of these ages. About 2 million were 16 or 17 years old.

In most areas April is a school month, and in the April 1945 survey it was found that 1¼ million of the workers 14 through 17 years who were employed in the census week also attended school in that week. Presumably most of these boys and girls worked outside school hours or on Saturdays and therefore may be classified as part-time workers. About half of the employed youngsters 14 through 17, however, did not attend school during the census week, and it is probably fair to assume that most of these had full-time jobs and had given up school, at least temporarily.

It is estimated that 550,000 of the million 14- and 15-year-old children who were employed during the census week in April 1945 were part-time workers, and 350,000 were full-time workers. Of the approximately 2 million employed youth 16 and 17 years old, 700,000 were part-time workers and 1,200,000 had full-time jobs. For a small number in this age group school attendance was not reported.

Nearly all the 6,300,000 boys and girls 14 through 17 years who were not in the labor force nor in the armed services attended school during the census week. This was true of both the 14-15 and 16-17 age groups.

Of the million workers who were 14 or 15 years old, 350,000 were employed in agriculture, 250,000 in trade, and the rest in various other industries. Of the approximately 2 million 16- and 17-year-old workers, 600,000 were employed in trade; 500,000 in manufacturing industries (including newspaper distribution for publishing companies); 400,000 in agriculture; and the rest in other industries.

A detailed analysis of this survey will be mimeographed.

CAMPS FOR CHILDREN WITH AND WITHOUT PHYSICAL HANDICAPS

If planning is carefully done, camping together can be a rewarding experience for both

by JUANITA LUCK, Consultant in Group Work, Social Service Division and BETTY HUSE, M.D., Assistant Director for Crippled Children, U. S. Children's Bureau

MORE THAN A SCORE of new developments have come within the camping field in the past few years. Farm camps, day camping in rural and urban areas, family camping—these and others illustrate a broadening of community camping services. Providing camping for children who have physical handicaps is another trend in the development of community camping resources for children.

Physically handicapped children who are able to participate in regular camping programs with nonhandicapped children should be given an opportunity to do so. Such a plan offers a challenge for both camping and medical personnel. Some voluntary agencies, organizations and individual camp directors have had experience in including physically handicapped children within their regular camp program. Public recreation departments have included some of these children in their day camping programs in some cities.

There is, however, limited experience in community planning for children with physical handicaps as campers with nonhandicapped children. For the most part, the physically handicapped child has been served in special or segregated camps under the sponsorship of public and private health and welfare agencies and organizations.

Camp is primarily a recreational experience with social, health, and educational values. All children and youth need experience through which they may have recognition, self-expression, spontaneous fun, and group acceptance. A physically handicapped child goes to camp for the same reasons as any other camper. He may want to try out his ideas, learn new skills, be with his friends, and make new ones. With the help of understanding camp counselors he can learn to make his way in the camp community.

Factors other than the ability to participate in physical activities are important in considering camp for a child. The daily pressure of living and playing in groups, learning new skills, and sharing responsibilities—these are all part of individual adjustment to the camp experience.

Understanding children with physical handicaps

A basic principle in providing services for children with physical handicaps is to consider all aspects of the development of the individual child: the physical, emotional, mental, and social. With this understanding, planning for children with handicaps should focus on their total needs rather than on planning primarily for the differences which may be inherent because of such handicaps. Cognizance of the real limitations of the physical handicap should, however, be taken by all persons working with the child, with an acceptance of the physical limitation and a knowledge of what this means to the child.

It is important to realize that the extent of a handicapping condition is often greater than meets the eye. A child may appear absolutely fit and well and yet he may be much more disabled than a child whose restriction is apparent as he attempts to move about in long leg braces. Such a child might be one with a cardiac involvement whose prescribed regimen demands marked restriction of activity. The child with diabetes is handicapped but such a limitation is less apparent and only under certain circumstances may be conspicuous to camp personnel and fellow campers. The handicapping conditions which do not show may require much more conscious consideration lest their full implications be overlooked in planning a camp program.

Children having the same type or similar handicaps cannot be considered alike in all aspects of their development. The meaning of the handicap is different for each child. Because of differences stemming from experience in family groups, in friendship groups, and other areas he may be expected to differ in attitudes, adjustment, and adaptability.

In many instances children with physical handicaps have undergone medical treatment which may have removed them from their family and neighborhood groups for a considerable length of time. Such separations may give rise to insecurity in being with children of comparable age, with children who are not handicapped, and in relations with their parents and other adults.

Therefore, opportunity for play, participation in group activities, and informal relationships with understanding adult leaders can make a significant contribution to the social development of these children. These considerations are important as they will affect relationships of a child while he is in camp and to a large extent may determine whether he should go to camp.

Can the handicapped child go to a regular community camp?

The handicapped child whose physical condition allows him to participate in enough of the camp program to become a part of it is the one who should be considered for camp. The decision as to whether a child with a physical handicap can or should participate in a reguar camping program depends funlamentally on knowledge of the nedical situation, including diagnoss, past history, present treatment, ınd recommendation, and their implications for the child in camp.

It is clear, for example, that a child vith a condition requiring intensive nedical treatment or bed rest should ıot be sent to a regular camp. If ı child is primarily in need of medcal care, other community resources would be more appropriate ıt the time, as such medical care vould not be available in a regular camping program. It is clear also hat a child who cannot move about or who is almost completely dependent on other persons for his personal ieeds in dressing and eating could ıot take part in the group life in a ısual camping program. For a large group of children with handicaps, ıowever, the decision will be more lifficult and can only be made on an ndividual basis.

The examining camp physician, after consultation with other physicians under whom the child is currently being treated, assumes the responsibility for deciding whether a child can go to camp and the extent of his participation in camping activities. The examining physician should have access to reports and recommendations from physicians who have had the responsibility for medical care of the child. This may include the family physician and specialists in the field covering the particular disability.

Public and private health and medical agencies provide consultation on matters pertaining to the physically handicapped child. Camping personnel should use such resources, where they are available from Federal, State, or local agencies. Every State has developed a State-wide program providing diagnosis, medical and surgical care, hospitalization, and after-care services for the physical restoration and social adjustment of crippled children. These State crippled children's agencies provide medical, nursing, medical-social work, and nutrition services and are resources in planning camp programs for these children. The State agencies work with public and private agencies in local communities in relation to services to crippled children. Agencies and groups planning to include physically handicapped children in camp should be familiar with the health and medical resources in their community such as local and State health departments, health sections of the council of social agencies, clinics, and hospitals.

Will camp contribute to the personal growth and social development?

Does the physically handicapped child want to go to camp? Much of the value of a camping experience begins when a child chooses this experience at a particular time in his development. Usually children wish to go to camp with their friends or acquaintances, or because they want to participate in camping activities. An expressed desire to go to camp may indicate the child's readiness for trying this experience. It is more difficult for a child to establish an informal relationship with other children and adults on a voluntary basis when he has been placed in a camp without an opportunity of making this choice for himself. A handicapped child may need help in deciding whether he wishes to go to camp with nonhandicapped children. Preparing him for this experience may determine to a great extent his ability to adjust to the camp group. Parents of handicapped children need to understand the camp program so they may share in this interpretation to the child. The medical-social worker, child-welfare worker, and public-health nurse may also help in such preparation.

GOOD CAMPING PROGRAMS give all children fun and adventure out-of-doors, companionship, and adult leadership, and for the child who is physically handicapped they may start the development of recreational interests that he will take back home.

The camp director must take responsibility for the pre-camp interviews as she or a member of the camp staff usually interprets to all campers what they may expect of the camp. Preparation for a camp experience and follow-up after camp is over are integral parts of the total camp experience for the child.

Will the child benefit from a camp experience? Some physically handicapped children may wish to go to camp but may not benefit from a regular camp program. They may not have accepted their physical limitations in a way which would enable them to take part in camp activities in a group of nonhandicapped children. Others may not be sufficiently mature to be able to function in a group situation in which a continuous process of give and take is required.

Is the camp program suitable for the handicapped child?

An organized camp program of the type offered in most communities by such agencies as public recreation departments, Girl Scouts, Boy Scouts, Camp Fire Girls, YMCA and YWCA, and by private camp directors may be considered for physically handicapped children. Information on available camps can be secured from councils of social agencies, the American Camping Association and its local sections, departments of public recreation, youth-serving organizations, and private camp directors.

Persons working with the physically handicapped child in their eagerness to help a child go to camp should not overlook the importance of selection of an appropriate camp. Several questions may be raised in selecting a desirable camp for physically handicapped children: Is the camp program one which would benefit the physically handicapped child? Does the camp provide adequate health, medical, and nutritional services? What is the understanding of the camp director and staff towards the inclusion of physically handicapped children in the regular camp program?

The camp director and staff share responsibility for each child in the camp group, with an acceptance of individual differences in the growth and development of children. The nonhandicapped child must be considered as well as the physically handicapped child if the camp experience is to be a satisfying one for all. Some children cannot understand physical limitations which they do not have. The way in which the nonhandicapped campers behave towards a physically handicapped child may greatly affect the kind of camp experience each will have.

There may be great value to the nonhandicapped child if he learns to work and play with the physically handicapped child—differences are better understood and accepted.

The camp staff should receive special help in working with physically handicapped children. This can be done in the counselor training period and with consultation during the camp period. The content of this training should include: (1) Understanding of children with physical handicaps and the implications for a regular camp experience; (2) acceptance of medical and health supervision in working with these children; and (3) maximum possibilities in the use of a program for handicapped children.

Good standards in personnel, facilities, and program considered necessary for all children are essential for a camp attended by children with physical handicaps. In addition, particular attention must be given to certain protective measures for the child with the physical handicap: for example, protective measures against undue exposure or changes in temperature. Services of State and local health departments should be used to insure health protection. Inspection and licensing of camps by the State department of health or other State departments may be required in some States. Sleeping arrangements, accessibility of toilet facilities, and type of dining-hall service must be planned in accordance with the physical condition of the children. The decision as to whether children may be in regular cabin units or in special sleeping quarters depends on the nature of the physical handicap and the specific recommendation of the physician. Some children may need special housing arrangements for their maximum protection but may easily participate in all other regular groupings for eating and recreation.

DIFFERENCES are better understood and accepted when handicapped and nonhandicapped children work and play together.

For some handicapped children maximum benefit can be gained if they can be grouped for certain purposes, such as special instruction in swimming or waterfront activities. Individualization to meet the special needs, whether in diet or leadership for activities, should be planned to help handicapped children make a happy adjustment in the total camp program.

The director and camp staff should plan the total camp program with an understanding of the maximum possibilities as well as limitations of the physically handicapped child in camp. This may include full participation in arts and crafts, music, dramatics, nature lore, camp crafts, and special events. Participation in camping activities which involve physical effort must be in accordance with medical recommendations.

It is assumed that adequate medical and health supervision would be provided for all campers. However, it is necessary to have specific knowledge of the needs of the handicapped child during his stay at camp. An approved activity plan for each child must be based upon the recommendations which the physician who is responsible for accepting campers makes to the camp doctor and nurse. The camp director and counselor directly responsible for the supervision of the child must understand the disability terms of both the limitations and ossibilities for the child's program camp. Usually the referring ealth agency or private physician responsible for joint consultation ith the camp doctor and director efore the child is accepted and durg the child's stay at camp. More rvice is required from nurses and her medical personnel where ysically handicapped children are cluded in regular camping proams. Special rest periods and ecial diets may also be necessary r some children upon recomendation of the doctor.

alues in camping for handicapped ildren

Going to camp is an experience ich is closely related to a child's lationships in his family, school, neighborhood groups. The camp oup, like the community back me, depends on children and ults working together toward als which they desire for their mp community. A camp experice can reveal significant and pertinent understanding of a child's interests and aptitudes. His parents, doctor, nurse, social worker, and recreation leader may want to know how he adjusted to his camp group, what new interests he may have developed, and whether his physical condition changed during camp. The camp director has a responsibility for making available selected material to other adults in the community who are working with the physically handicapped child. The camp physician should prepare a medical report which would be helpful to the clinic, health agency, or individual physician. Such information may be made available through conferences, joint agency consultations and carefully prepared written reports.

Spontaneous fun in informal groups at camp may be a beginning of the development of recreational interests for some children. Participation in community recreational programs could be a helpful next step. Camp leaders can interpret the recreational opportunities which are available in such groups as Boy Scouts, Boys' Clubs, Girl Scouts, YWCA, YMCA, Camp Fire Girls, public recreation departments, 4-H clubs, and school- and church-recreation programs. Individual campers may be helped in seeking information about neighborhood activities from public and private recreational agencies. Councils of Social Agencies and recreation councils may be resources in helping these children find community recreational interests to supplement their camp experience.

Organized camping at its best has permanent values for children. A good camping program gives children fun and adventure out-of-doors, companionship with other children, and adult leadership.

Camping and medical leaders are becoming increasingly interested in the value of camping experience for the physically handicapped child. Any plan for camping service in a community should consider the needs of the physically handicapped child.

A limited supply of reprints of this article will be available from the Children's Bureau, Washington 25, D. C.

Families Kept Together Through Work of Homemakers

Emergency housekeeping service, ovided by a responsible social ency, is keeping many families tother that were on the verge of a eak-up because no one was availle to act as homemaker. Such a mily break-up, of course, often eans that one or more members, ually children, are placed in an stitution or a foster home.

Examples of such service, public d private, are reported from reat Britain and from New York ty.

ome helps

The Health and Labor Departents of the British Government e collaborating in helping to prode home help in emergencies. ocal authorities pay the women cruited to do this work, and the useholders that receive the help ntribute according to their means.

The "home helps" are available to useholds that need them for spefied emergencies; for example, here the housewife needs help because she is expecting a baby, or if the mother of small children is suddenly called to see her husband in a hospital; or if she herself must have an operation or is ill; or if several members of a family are ill at the same time; also if old people are ill. There is no age limit for women who wish to do this work. Married women as well as single ones are eligible. Full time or part time may be given.

Mothers' aides

To prevent temporary commitment of children to institutions, New York City's department of welfare has established a program under which "mothers' aides" will be assigned to take care of children in their own homes while the mother is ill, either at home or in a hospital. Forty-five such aides, as well as a supervisory staff of five, are to be engaged in the fiscal year 1945–46.

A 3-week course of intensive training at the department of welfare's homemaking center will be given the mothers' aides. The subjects will include child care, nutrition, marketing, meal planning, care of the house, laundering, care of clothing, and home care of the sick. After taking this course the aides will be expected to assume complete responsibility for the household during a mother's disability.

Mothers' aides will be assigned not only to families receiving public assistance, but to any family where such service is needed in order to prevent commitment of children to an institution. The aides will be paid $1,440 a year and will work 6 days a week, 8 hours a day.

Visiting housekeepers

Six private social agencies in New York City now operate housekeeper programs. Last year more than 1,000 families received housekeeper service through these agencies and a large number of applications had to be rejected because of lack of housekeepers or lack of funds.

PLANNING SERVICES FOR CHILDREN GETS UNDER WAY

Six State legislatures put planning bodies to work for children

A NEW CHAPTER in the movement for planning by States is beginning to be written, and it concerns children. Just as the first World War gave planning by cities its great impetus, the second has speeded up the movement for State planning. And now States are seeing the value of blueprinting improvements and expansion not only of their physical resources but also of their services.

At least six State legislatures—Georgia, Illinois, Kentucky, Michigan, Missouri, and New York—have set up special bodies to deal with services for youth. In some instances—Georgia is one—the youth program is being developed as part of a broad program of social planning for the whole population; in others the governmental unit is specifically charged with planning for youth; and in still others, its responsibility is in specific fields, such as child-welfare legislation or prevention of juvenile delinquency. Other States, in one way or another, according to reports that have come into the Children's Bureau recently, likewise are tackling on a Statewide basis what is to be done for children and youth in the postwar world.

In many instances present action by the States is the direct outcome of steps taken during the war years to focus attention on the need to make planning for children and youth a special concern of government, working with citizens' groups of all kinds. What is being done, as is apparent from the summary of State programs that follows, varies greatly, but the point is that States and communities, more aware perhaps than ever before of the great disparity in services to children and youth within the State and the community, as within the Nation, are now taking hold of the chance "to do it over and do it better." In their efforts to do so they are drawing into the planning a wide representation of community interests, as for instance, in Michigan, where a youth-guidance advisory council has on it representatives of various child-welfare, social, health, and law-enforcement agencies, as well as labor, industry, parent groups, adult education, colleges, farms, and youth-serving organizations.

This planning for children and youth that is being done in the States is in line with the proposal made by the National Commission on Children in Wartime, in its postwar prospectus, "Building the Future for Children and Youth" (Children's Bureau Pub. No. 310) and set forth in amplified form in a special publication, "State and Community Planning for Children and Youth" (Children's Bureau Pub. No. 312). Individual copies of this publication may be had without charge, as long as the supply lasts, from the Children's Bureau, U. S. Department of Labor, Washington 25, D. C.

The Commission, in its recommendations, draws upon wartime experience in showing the obstacles that must be overcome if planning for the postwar needs of the Nation's youth is to be of its maximum usefulness. Such committees in the war period had to struggle against limitation of authority, the absence of clear-cut definition of functions, overlapping of committees, and especially, lack of financial resources for essential leadership and staff service.

To be effective, a planning body for children and youth, the Commission points out, must have the following characteristics: (1) recognized authority; (2) clear-cut definition of function and of relationships to other planning bodies and administrative agencies; (3) membership broadly representative of various interests, official and unofficial, and of majority and minority groups in the population; (4) effective organization of work through executive and other subcommittees; (5) resources for the employment of an executive secretary and necessary staff, and for other expenses.

The Bureau will be interested in hearing what is being done in other States.

Alabama

The State committee on children in wartime is to be continued as the State advisory committee on children and youth. Dr. J. S. Hough, acting director of the Bureau of Maternal and Child Health, will serve as chairman.

Georgia

The Georgia Citizens Council, authorized by law in March 1945, is carrying on many of the activities developed under the former Volunteer War-Service Council. The council is made up of representatives of State departments of educa-

tion, welfare, and health, private State-wide agencies, citizen groups, labor groups, judges, attorneys, and other persons interested in child welfare.

The council has a youth division which is under the chairmanship of Mrs. Robert A. Long (273 Capitol Avenue SW., Atlanta). The objectives of the division are to stimulate community programs for youth; to encourage the formation of community-wide committees which would marshal all resources to provide youth an opportunity of participating in community service; and to promote the use of school and church facilities for youth activities.

The youth division has the following subsections:

Preschool section—to deal with day-care services for children of working mothers.

Parents and community cooperation section—to deal with leisure-time activities and extension of juvenile-court service.

Junior citizenship section—to deal with citizenship training and leaders for youth-serving activities.

Child-labor section—to deal with passage of 16-year child-labor bill.

Teen-age-center section—to deal with training leaders for recreation programs, character building, and development of talent.

Illinois

The Child Welfare Commission (or "Baker Commission"), created by the legislature in July 1943, was extended for 2 years by the 1945 legislature, which appropriated $25,000 to finance the commission for that period. The commission is authorized "to prepare and develop a program designed to consolidate and coordinate the administration of the child-welfare functions of the State" and will submit its developed program and recommendations to the 1947 legislature. Mr. Chauncey McCormick is serving as chairman; Mary Zahrobsky (c/o Ernest Freund, 135 South La Salle St., Chicago) as secretary. The membership consists of three members of the senate, three members of the house of representatives, and three private citizens.

Kentucky

The Kentucky Youth Guidance Commission was authorized by the legislature in March 1944. Mr. Joshua B. Everett of Frankfort was appointed chairman and Dr. W. E. Watson (Mental Hygiene Division, State Department of Welfare, Frankfort) executive secretary. The act provides that the committee consist of nine members representing the nine congressional districts to be appointed by the Governor—three from welfare and religious agencies, three from the teaching profession, and three other persons "competent and interested in the education and welfare of youth." The Commission is set up to study and to make recommendations to the Governor on the following subjects: (1) general welfare of the children of the State; (2) character education in the schools; (3) character building organizations; (4) existing laws affecting children and their influence on juvenile delinquency. County committees have also been organized in each of the 120 counties of the State to survey the local situation and discover what needs exist and what facilities are available for meeting them.

On February 14, 1945, the Committee for Kenutcky was organized with Dr. Ernest Green Trimble (University of Kentucky, Lexington) as chairman. The stated purpose of the Committee is "to attempt to find out what is wrong with Kentucky." It is made up of 70 or more members representing various civic, business, labor, farm, and professional groups. Ten problems have been selected for study by subcommittees headed by experts in their particular fields. These include health, education, labor, and public welfare. A 3-year program is planned in which the committee will study the facts and endeavor to enlist support throughout the State in meeting discovered needs. Its activities are being coordinated with those of the postwar advisory committee. The committee is financed by member organizations whose individual contributions range from $25 to $1,000.

Maryland

Early in October 1945 the Governor appointed a State youth-service commission to plan for children and youth and to discuss legislation needed in their behalf. Mr. Joseph Rogan (State Parole Commission, Baltimore Trust Bldg., Baltimore) has been appointed chairman. The membership includes representatives from the State departments of welfare, education, and mental hygiene, the State parole commission, the juvenile division of the circuit court of Baltimore County, the superior court juvenile judge of Baltimore, and the superintendent of the State training school for girls. The Governor has also appointed a State committee to study adoption legislation, with Judge Eugene O'Dunne as chairman, which is expected to work with the commission.

Michigan

In 1943 the Governor appointed the youth-guidance commission, with Eugene B. Elliott as chairman and Walter M. Berry (230 North Grand Avenue, Lansing) as executive secretary. The 1945 legislature voted to authorize the Commission to continue until July 1, 1947 and appropriated $75,380 to cover the 2-year period. The objectives of the commission are: (1) To develop and strengthen all resources for children operating through the home, the schools, or the community; (2) to bring about more effective control of influences detrimental to youth; (3) to develop and strengthen services for children who are in danger of becoming delinquent; (4) to improve services for delinquent children and children with behaviour problems. County and local youth-guidance committees have been formed in most of the 83 counties of the State.

The Michigan Youth Guidance Advisory Council has been organized to serve with the Commission in an advisory capacity and to meet the need for representation of public and private youth-serving organizations in the State. The advisory council has 70 members representing various child-welfare, social, health, and law-enforcement agencies, as well as labor, industry, parent groups, adult education, colleges, farms, and youth-serving organizations.

Mississippi

A joint committee of the senate and house is considering child-welfare legislation in Mississippi. In September 1945 the Governor appointed a group of citizens representing the various public and private agencies in the State concerned with child welfare to serve with the joint committee as a children's code commission. Governor Thomas L. Bailey will serve as chairman of the Commission.

Missouri

In July 1945 the Governor signed the act establishing the children's code commission and has since appointed five members to the Commission. Mrs. Reding Putnam (800 West 58th Street Terrace, Kansas City) will serve as chairman. The Legislature has appropriated $12,000 to cover the expenses of the commission for the fiscal year 1945–46; of this $7,500 will be used for personnel.

New York

The 1945 legislature has established the State youth commission, with Mr. Emmet R. Gauhn of Albany as chairman and executive director. The commission is to operate for a 2-year period, at the end of which time it will be decided whether to make the commission a permanent agency or discontinue it altogether. The commission's responsibilities during the next 2 years are:

1. To study problems in youth guidance and the prevention of juvenile delinquency
2. To pass on plans for youth bureaus and recreation and education projects
3. To develop educational programs connected with delinquency
4. To authorize payment of State aid to municipalities for youth bureaus
5. To foster cooperation between State departments, public and private agencies, and volunter local committees throughout the State, with the purpose of:
    a. Stimulating more effective use of existing community resources and services.
    b. Recommending new services.
    c. Stimulating programs for the prevention of juvenile delinquency.
    d. Developing closer cooperation among local employers, labor organizations, schools, churches, recreation commissions, employment bureaus, service clubs, and other public and private agencies interested in furthering sound youth programs and fair employment practices for youth in their communities.

The 1945 legislature also provided for local bureaus in an amendment to the general municipal law, as follows: "Any municipal corporation is hereby authorized and empowered to establish, maintain, and operate a bureau or agency thereof for the purpose of coordinating and supplementing the activities of public and private agencies devoted in whole or in part to the welfare and protection of youth therein and to undertake and promote activities and establish, maintain, and operate projects devoted in whole or in part to providing leisure-time activities for youth or assistance to children."

With the exception of 14 up-State centers which closed voluntarily, the child-care centers sponsored by the State committee on child labor, development, and protection, of the State war council will be continued until March 31, 1946. It is felt that these centers will continue to be needed since most of the children served by them are children of servicemen or of mothers who are the sole support of their families. Four new centers which were approved before V-J Day have been authorized to open in New York City.

North Carolina

In October 1944 the State planning board appointed the Committee on Security and Services for Children in North Carolina, with Dr. Gordon Blackwell (University of North Carolina, Chapel Hill) as chairman. One of the objectives of this group is "to pool the planning of the various State departments in regard to children." Funds are to be obtained to employ a full-time secretary who will study the needs of children throughout the State and make recommendations regarding organization and funds. During the 1945 legislative session the committee served as a clearing house for legislation affecting children proposed by various State departments.

Pennsylvania

A cooperative program has been started by the youth-conservation committee of the State Federation of Women's Clubs and the State department of public welfare, for the purpose of studying, analyzing, and improving conditions for children and youth in Pennsylvania. A "Pennsylvania Bill of Rights for Every Child" has been agreed upon. A bulletin, "Youth Conservation—Our Responsibility," and a study outline have been prepared by the department of public welfare for the use of local clubs and other community groups in studying and evaluating services for children and youth.

Tennessee

In September 1945 the Tennessee Conference of Social Work appointed a children's commission on legislation. Senator Kloak Weimar of Davidson County will serve as chairman of the commission.

Other State committees

According to latest information the following State committees or councils, active during the war, are being continued:

Kansas Council for Children.

Oregon Advisory Committee on Child Care, Health, and Welfare.

In some States there are other representative committees which are concerned with a special phase of activity for children and youth.

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The CHILD

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- What Mothers Think About Day Care
- Social Workers Look at Adoption
- Helping the Hard-of-Hearing Child

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Reprints of the center spread, "To Make 1946 a Banner Year for Children," are available.

U. S. DEPARTMENT OF LABOR
L. B. Schwellenbach, *Secretary*
CHILDREN'S BUREAU
Katharine F. Lenroot, *Chief*

A JOB FOR YOU

Whether the world is to have an enduring and a just peace is going to depend in the long run upon what we do for the children, not only our own, but all children.

This Nation, like every other nation, must be concerned now about the stamina of its people and their ability to climb the long, uphill road leading to the realization of the aims for which this war was fought.

The most important long-range issues that confront us today therefore have to do with our children and youth. The kind of homes in which they are reared, the schools they attend, the communities in which they live, the spirit and purpose of the Nation as a whole, these will determine how well our responsibility to them, and to the Nation and the world, is met.

Practical steps that communities can take in meeting their responsibilities call for:

1. Housing fit for children—without this much of our planning must come to nothing.

2. Prenatal care for all mothers and child-health services for all infants and preschool children.

3. Health centers and hospitals for the whole community—well built, staffed, and equipped to give good care to all mothers and children.

4. Health programs for all school-age children and employed youth, with medical, dental, and nursing service and health education.

5. Nursery schools and kindergartens for preschool children.

6. Schooling for all children and youth, with good buildings and equipment, well-paid teachers, full terms, and well-rounded programs.

7. School lunches available to all school children, with all children treated alike—through a good school lunch we can make up to some extent for the inadequate diets many have.

8. Recreation programs for all ages.

9. Child-welfare services, well-staffed and with adequate facilities for children needing special care in their own homes or in foster homes.

10. Day-care programs for children whose mothers are employed and for all other children requiring care away from home during the day.

11. Counseling and child-labor law enforcement to help boys and girls prepare for what they want to do and find suitable jobs.

12. Good local government, mindful of the problems and needs of children and youth, with opportunity for youth to share responsibilities.

The job, of course, cannot be done by communities alone, for community resources vary. State and Federal Governments also have a responsibility, but the place to begin the job is where the children are. Every community should have within it a group of citizens officially entrusted with the responsibility for planning for its children. They must be aware, also, of the needs of children the country over, for no community can live alone. What happens to children anywhere has a direct relation to the future opportunity and well-being of all children everywhere.

While planning for our own children, we must also feel concern for the world's children, many of whom are living under hardships even greater than those suffered in the war years. We must get help to them now—all the help we can—for humanitarian reasons, which are sufficient enough. In so doing we will help them, as we help our own, toward a better world, a world in which today's children, then grown, can live in peace, freedom and security.

Katharine F. Lenroot

Katharine F. Lenroot,
Chief, Children's Bureau.

Publication of The Child, Monthly Bulletin, with Social Statistics supplements from time to time, was authorized by the Bureau of the Budget, May 12, 19 under Rule 42 of the Joint Committee on Printing, to meet the needs of agencies working with or for children for a regular channel of information on current dev opments, activities, policies, and programs for maintaining the health of mothers and children, providing child-welfare services, and safeguarding the employment o youth. Address The Child, Children's Bureau, U. S. Department of Labor, Washington 25, D. C. The Children's Bureau does not necessarily assume respon bility for the statements or opinions of contributors not connected with the Bureau. The Child is for sale by the Superintendent of Documents, Government Print ing Office, Washington 25, D. C.. at $1 a year; foreign postage, 25 cents additional; single copies, 10 cents.

WHAT MOTHERS THINK ABOUT DAY CARE

Cleveland, Ohio, mothers mobilize to put a wartime service for children on a permanent basis

by *GLENNA B. JOHNSON*
Emergency Child Care Office, Cleveland

• **IF CLEVELAND, OHIO,** is any sample, there is as much chance of persuading working mothers to go back to the prewar style of day care for their children as there is of persuading a washing-machine manufacturer to go back to producing a prewar model. These working mothers not only do not want to go back; they want to work things out so they will not have to.

Trial-and-error method out of date

Through their wartime experiences they now know that there is something much better than the trial-and-error way of finding care for their children. They know that the risks their children often ran because mothers had to depend on answering or inserting ads, trying this or that commercial resource, are not inevitable. Above all they know how much better children, mothers, and families thrive when they work out their child-care problems on a community basis.

For the first time many mothers actually "shared" the care of their children in joint planning of day-care services. In many places—Cleveland was one—where day-care services included health, education, and social case work, skilled workers shared responsibility with mothers. From them mothers learned things they had not known before about the growing needs of their children. They saw their children respond to different ways of care and had a chance to talk about the behavior and reactions of their children with people trained in child development. They learned that working out child-care problems together produces results that working at them alone often failed to achieve. How well they learned all these things came out suddenly and dramatically.

On August 17 the Federal Works Agency, which had been supporting day-care centers, announced that this support would be withdrawn on October 31. It was as if a bombshell had hit Cleveland when this news became known to parents and staff on August 21. Within 10 days the mothers in over 90 percent of the day-care centers had organized, elected officers, appointed committees, and worked out a planned program of social action—city-wide, State-wide, and National in scope. Teachers and case workers were invited to sit in on their meetings. Mothers, struggling with problems of a constitution, representation, cooperation with other civic and social-welfare groups, were putting democracy into high gear.

"Through this terrible war," a Cleveland mother, addressing a group of other mothers, said, "there isn't one of us in America who hasn't promised herself a better world after all the fighting and killing is over. Now the time has come to turn these dreams and promises into action. The time is ripe and the people ready. It is up to us to offer a program and a plan for children. We know we will succeed."

What these mothers-in-action wanted was a continuing program that, unlike the emergency one which had been based on the needs of industry, was planned to meet the needs of their children. But first they had to meet the sudden curtailment of even the emergency program. To muster community support for their day-care program mothers went calling on the leading citizens and groups of the city—clergymen, businessmen, labor leaders, the Welfare Federation, officials of the city and county government. They sent a delega-

SAFE AND HAPPY at the day-care center, these youngsters think the teacher's big picture book is pretty nice; all except one, who is wishing for naptime.

OWI photograph by Marjory Collins

tion to the Governor and two representatives to Washington who interviewed all the Congressmen and Senators from Ohio. Other mothers secured radio time for an interpretive skit and innumerable spot announcements and wrote up their case for the newspapers. A mass meeting was organized. Speakers included a member of Congress, a State senator, the mayor of the city, the juvenile-court judge, officials of labor unions, the dean of the school of social work, a chaplain from the veterans' hospital, who spoke for GI's on what they wanted for children and how day care fitted in. "Do you realize," one of the mothers remarked when the campaign for day care for children of Cleveland's working mothers was at its height, "what a community education experience this is for most of us? We could never have learned so much about our government and how it works and what is back of all our many welfare services."

How well do the mothers understand what they are asking for? While social workers have not been surprised that mothers should seek, with every means possible, to continue their program, some have been amazed at the clarity and effectiveness with which they have told what day care has meant to them and their children.

Child needs skilled guidance

There was the widowed mother who presented a graphic picture of her loss and loneliness at the death of her husband and of her effort to keep her home together through her work and the services of several housekeepers. These housekeepers could not understand her 4-year-old daughter's handicap, partial vision. They were making a "mental cripple" out of her by their well-meaning "Don't do this" and "Don't do that," for fear the child would harm herself. This mother told of the sympathetic understanding of her situation by the case worker and the thought that worker put into preparing the child for the day-care center. She could not say enough for the skilled guidance of the teachers, who let her child do most of the things other children did, even to climbing the "monkey bars."

"Where are our local social agencies in this picture?" another mother asks. "Don't they know that this is the best thing society has set up to meet our needs? They can't let it go. This is the best way of preventing juvenile delinquency I know anything about."

Another mother asks challengingly: "What if some of the parents aren't assuming all their responsibilities? You can't make them all over after they are grown up, can you? How does it help a child just to condemn his parents and try to get them to do things they can't do?"

Who needs child-care service?

"Certainly servicemen's wives need this," says one mother, "but some of the rest of us have needed a service like this, too." She is questioned by a mother who is not sure that they have a right to ask for a public child-care service for any child. Shouldn't it be for just those who need it? Promptly the questions pour in on this doubting mother: "But how do you decide who needs it?" From the heated discussion that follows, it is clear the majority believes that in a democracy the parent is the one to determine her own need and that of her child, and to decide the best way to meet such needs.

Emotional as well as economic needs are stated and recognized as a valid reason for a day-care service. "Isn't that why we have trained consultants on this program, to help us make up our minds what is best for ourselves, and then to stick by us if we have trouble carrying out our decisions?" Shyly, one mother volunteers, "We must tell people that the day-care center is a place for mothers, too. I know I'm a better mother than I used to be before Jean went there. I'm learning every day."

Still another mother, when asked what she had appreciated most about the service, thought it was the sympathetic, intelligent guidance of the teachers and the happy smile on her child's face as she left her in the morning. Then she added, "It's just everything about it; my child and I are both welcome; the staff is there for both of us."

Roles of teacher and case worker

Little persuasion has been needed to make mothers see the value of the teaching and child-development aspects of the day-care program. The role of the teacher who serves as a warm, friendly, experienced guide of a young child through most of his waking day is easily understood. The health aspects, too, are accepted. Even when vaccination or immunization causes havoc in a mother's workday schedule, the day-care center's right to be concerned with her child's health is usually welcomed. What is not so instantaneously understood or easy to interpret is the value of casework service. From the start of the program, in one way or another, this service has been an integral part of the Cleveland program. Now, after nearly 4 years of experience and demonstration, this service has become so valuable to the mothers that in petitioning for the continuation of the program they have included it as one of the essential ingredients in a total day-care plan.

Most mothers know well that their young child requires a sense of security and belonging to an adult in the warm, affectional relationships of daily contacts. Meeting such a need is difficult when the parent who is the chief source of this affectional relationship is herself subjected to the threefold strain of carrying a job, managing her household, and caring for her child. Servicemen's wives have been carrying still another burden in their anxiety and fear over separation from their husbands. Furthermore, such women do not have the usual opportunities of young mothers to share with the father the normal anxieties and problems of parenthood. Even where the father is not in service, a third of our mothers using day care are separated, or divorced, or their marriages are acknowledged to be unstable.

These considerations make skillful counseling by case workers vitally important all the time that a family uses the day-care center, but especially at the time of application. Here the groundwork of continued service is laid, and the mother is encouraged to understand that she may see this person from time to time as her need or her child's requires and to plan with the worker for his development.

At intake, the case worker helps the parent to weigh the values to herself and her child if she is embarking for the first time on a job outside her own home. Even where mothers have worked before, they have usually depended on a relative or friend or hired help for the care of their children, and have had little understanding of what the changes in this new form of child care will mean for themselves or their children. Just having the chance to talk over her need for a job and what the separation from her child will mean to both of them sometimes spares a mother and a child the stress and strain of embarking on a hasty and ill-thought-out plan.

The case worker and the head teacher, at intake, together have a chance to prepare both the child and the parent for the actual use of the service. The teacher and social worker give the parent detailed information about hours, fees, schedules, clothing, and medical care. The case worker handles any follow-up questions the parent may have about the day-care plan itself, and secures a picture of the child's developmental and social adjustment up to now.

Throughout the child's enrollment, the case worker is available to the parent for discussion of problems as they arise and for review of the day-care plan from time to time. No family situation remains static, and changes in any family set-up can alter the satisfaction of the child and parent in using the service. For example, a father may return home emotionally disturbed and shocked from the war, and a previously happy and well-adjusted child will show the stress and strain through which his parents are going.

LEARNING TO PLAY HOSTESS, Lillie is passing carrot sticks to the other children at the day-care center. Bill can't make up his mind which piece to take. The center serves lunch as well as midmorning and midafternoon snacks.

OWI photo by Rosener

At the time the child leaves the center, the case worker discusses with the parent what the ending of this experience means for herself and her child.

As a member of a team working with all the staff for the best use of day-care services by parents and children, the case worker serves as a valuable link between the center and the child's own home, helping to build up a mutually accepted and workable sharing of responsibility between both. When necessary she interprets community services to parents and helps them to find what services they may need from other agencies.

Want voice in determining policies

Only a reprieve on the closing date of their emergency day-care program has been won by the Cleveland mothers who have so valiantly mustered to its defense, but their determination not to stop there continues strong. When they get their permanent program they want a voice in determining its policies.

They base their hopes for a long-range program available to any child who needs it, not only on their own efforts to interpret their need, but on the conviction expressed in the White House Conference report of 1940 which states: "Public child-welfare services should be available to every child in need of such help, without regard to legal residence, economic status, race, or any consideration other than the child's need. The local public welfare department should be able to provide all essential social services to children, either directly or through utilizing the resources of other agencies. Public and private child-welfare agencies should cooperate in a program which will assure the proper service to every child in need."

One mother sums it up: "In a democracy attention should be focused on the child. It is to this generation that we are giving the atomic bomb. We plan for day care with the full knowledge that a mother cannot give security to a child unless she has it herself."

Reprints available on request

PROTECTION OF MOTHERS AND CHILDREN IN PERU

by ANNA KALET SMITH
Office of the Chief, U. S. Children's Bureau

● **PROTECTION** of mothers and children in Peru, to which the Government of that country has been devoting much attention in recent years, made significant progress in 1940–44. Facilities for the care of maternal and child health have been expanded in Lima and other cities, and have been introduced in rural districts with rapidly increasing aid from the Government. For the greater effectiveness of the work, training has been made available for health and welfare workers, who are now employed in steadily growing numbers; and social service has been placed on a new basis, with help in one form or another extended to the family as a unit, instead of being limited to the individual applicant.

National Service for the Protection of Mothers and Children

The work that was previously centralized in the National Institute of the Child has been transferred to the newly organized National Service for the Protection of Mothers and Children (Servicio Nacional de Protección Materno-Infantil), which replaces the Institute. The National Service is the technical executive agency of the National Bureau of Public Health. It coordinates and directs health and welfare work for expectant mothers, babies, and young children, whether done by public or private agencies. It maintains prenatal centers, child-health centers, day nurseries, lunch rooms for mothers, and vacation homes for children. It also maintains such facilities as a school for mothers, a child-guidance clinic, a nutrition clinic, and a system of social service and legal aid to families.

The work of the National Service for the Protection of Mothers and Children is done through five divisions:

(1) The Division of Aid to Mothers directs the work of the prenatal clinics and lunch rooms for mothers in Lima and elsewhere and takes care of all matters relating to attendance at childbirth in the home. Under a new arrangement, aimed at meeting a very acute problem, midwives are employed by the National Service to attend at childbirth free of charge women who cannot pay a private midwife, or who for personal or family reasons are unable to go to a public hospital. A prerequisite for this form of aid is an examination of the prospective patient at a prenatal clinic during her pregnancy and an investigation of her case by a social worker. The midwife attends the patient not only at childbirth but also during the postpartum. The necessary medical supplies are provided at public expense.

(2) The Division of Child Health deals with the health of children from birth until the beginning of school attendance. This Division is particularly concerned with prevention of disease and the reduction of infant and child mortality. In an effort to achieve these purposes the Division has recently introduced in Lima an arrangement whereby health workers visit mothers and babies. Visits are made several days after birth to children who were born in the public maternity hospital in Lima (they represent 60 percent of the births in that city) and to those born in their own homes whose mothers had been attended by midwives of the National Service. The mothers are instructed in child care. Special attention is given to prematurely born infants, for whom incubators and other services are provided. The system of visiting is being extended to other cities as trained workers become more readily available.

(3) The Division of Public Health studies problems relating to family health and welfare. Much attention is given by this division to health education of mothers. At the "center of mothers' education" in Lima women and girls are taught child hygiene, dietetics, and sewing; individual advice is given on feeding children; facilities are available for immunizing children against infectious diseases; a library for parents and a permanent exhibit on child care are maintained. The mothers in some localities outside Lima receive health education from physicians, nurses, or midwives.

(4) The Division of Mental Hygiene of the Child is concerned with behavior problems of children. A child-guidance clinic has been operating in Lima as a part of this Division since 1943. Cases of mental defect and behavior problems are treated at the clinic, and parents are advised on the care and training of their children. Psychiatrists, a psychologist, a nurse, and social workers are employed. The latter visit the children's homes in an effort to ascertain the nature of the problem and to provide the treatment prescribed at the clinic.

(5) The Division of Social Service investigates the cases brought to its attention and aims to give economic, legal, and social aid to families and particularly to unmarried mothers. An important part of this Division's work is the placement of children who either have no homes or must be removed temporarily from their homes because of the mother's illness or for other reasons. Owing to recognition by social workers of the value of family life for children and also because of the shortage of institutions in Peru, most of these children are being placed in foster families. In some cases the children receive free care; in others, their board is paid from public funds, with their parents contributing according to their ability. The work of this Division has increased in Lima and has been extended to other parts of the country. Thirty so-

cial workers, graduates of the school of social service in Lima, were employed in that city at the end of 1944.

Facilities maintained by the National Service in Lima and Callao

In Lima the National Service for the Protection of Mothers and Children maintains the following facilities: A central dispensary, which includes an ear, throat, and nose clinic, an eye clinic, an X-ray department, a bacteriological laboratory, and a dental clinic; 19 health centers, some of which serve mothers and children, others children alone; 4 lunch rooms, 6 day nurseries, a central office of social service, a child-guidance clinic, a nutrition clinic, and a school for mothers. In Callao, the National Service maintains 5 health centers for mothers and children, a mothers' lunch room, a day nursery, and an office of social service.

Departmental Institutes of the Child

Outside Lima the National Service maintains Departmental Institutes of the Child in the capitals of 14 of the 22 departments into which Peru is divided. Nine of these institutes were established in the last 5 years. These institutes, which act as branches of the National Service, provide medical and other services for mothers—prenatal care, delivery, and postnatal care—and for infants and young children.

The institutes administer the work in the capitals and report on it to the National Bureau of Public Health. In some capitals they have introduced social services and have set up lunch rooms for mothers.

A CHILD-HEALTH CONFERENCE at Tamashiyacu, Peru, on the Amazon. It is part of the work of the Inter-American Cooperative Health Service.

C. I. A. A. Photo

Outside the capitals of the departments similar work, but on a more limited scale, is done in several cities and in some rural districts. The rural work is directed and supported by the Inter-American Cooperative Public Health Service. This cooperative service was established in Peru—and similar ones in several other countries—in accordance with a plan for the improvement of public health in individual countries, made at a meeting of representatives of the American republics in 1942. In each country agreeing to the plan, the service is financed jointly by the United States and the Government of the country concerned and is directed jointly by representatives of the two countries.

Child-health services by other departments of the Government

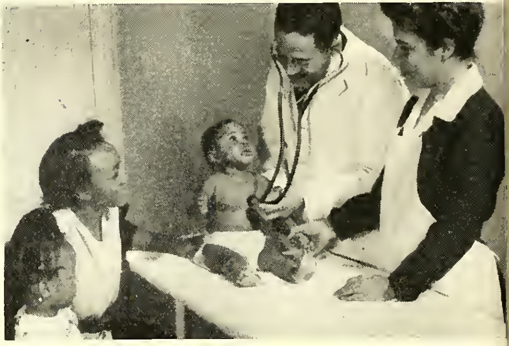
In addition to the National Service for the Protection of Mothers and Children other Government agencies are engaged in work for children. The Ministry of Education has recently embarked upon an extensive program of health work for school children, including regular medical examinations, dental services, and physical education; the Ministry of Justice maintains institutions for children presenting behavior problems; the Bureau of Social Welfare in the Ministry of Public Health and Social Welfare supports the Children's Hospital in Lima and several school-lunch programs in that city. Institutions for dependent children and hospitals and clinics for mothers and children, whether belonging to municipalities or to private organizations, are subsidized by the Government.

All this work now done in Peru on behalf of mothers and children is to be unified into one system after the expected enactment of the "Minors' Code," a draft of which has been recently sent to Parliament by the executive branch of the Government.

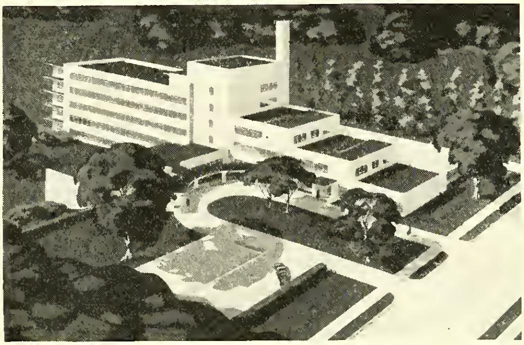
SOURCE: *Boletín del Servicio Nacional de Protección Materno-Infantil, Lima, January–June 1945*

TO MAKE 1946 A BANNER YEAR FOR CHILDRE

1 HOUSING that is fit for children, with adequate space for the whole family; good light, ventilation, and sanitation; and room for the children to play indoors and outdoors.



2 PRENATAL CARE for all mothers, and child-health ser
ices for all infants and preschool children, to save mot
ers' lives and give children a good health start in li



3 HEALTH CENTERS and HOSPITALS for the whole community, which are well built, well staffed, and well equipped to provide good care to all mothers and children.

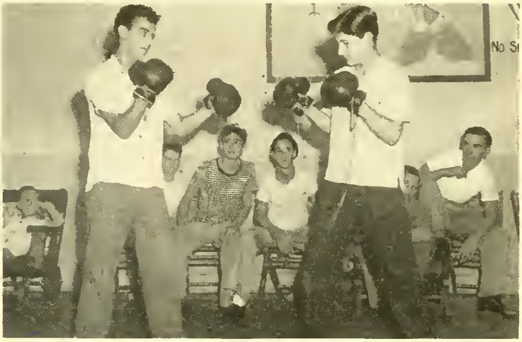
4 HEALTH PROGRAMS for all school-age children and f
all employed youth. Such programs would provide medic
dental, and nursing services, and also health educatio

5 NURSERY SCHOOLS and KINDERGARTENS for children too young to go to regular schools with opportunities for happy, varied play under guidance of wise teachers.

6 SCHOOLING for all children and youth, with good buil
ings and equipment, well-prepared and well-paid teache
full school terms, and well-rounded educational program

Here are 12 program ideas for citizens who want their communities to be a happy growing ground for all children and are willing to work to make them so

7 SCHOOL LUNCHES available to all school children, with good food that rounds out their day's food needs, and no discrimination between children who pay and do not pay.



8 RECREATION PROGRAMS FOR ALL AGES, with active games and quiet play, dramatics, arts, crafts, and music, and sympathetic adult supervision over these activities.

9 CHILD-WELFARE SERVICES, well staffed and with adequate facilities, for all children who are in need of special care in their own homes or in foster-family homes.

10 DAY-CARE PROGRAMS for children whose mothers are employed and for other children who require care away from their own homes during the daytime.

11 COUNSELING and CHILD-LABOR LAW ENFORCEMENT to help boys and girls prepare for what they want to do and find suitable jobs when ready for work.

12 GOOD LOCAL GOVERNMENT, concerned with the many problems and needs of children and youth, with opportunities for youth to share in some responsibilities.

SOCIAL WORKERS LOOK AT ADOPTION

Agencies helping unmarried mothers meet to criticize their own methods of work

• **RECOGNIZED** social agency or unauthorized intermediary—which of these two can best meet my needs?

This hypothetical question, posed by a hypothetical unmarried mother—and by persons seeking to adopt her child—was the central point of a recent panel discussion of the topic, "How can we achieve safer adoption policies?"

Participating in the discussion, which was held as part of the New York City meeting of the National Conference of Social Work, were social workers, a psychiatrist, a doctor, and a judge.

An abridgment of the discussion is presented here, without identification of the participants.

The lures of unauthorized adoption services

What are the lures of the unauthorized placement? The fact that a large number of unmarried mothers, and persons who wish to adopt a child, turn to unqualified intermediaries rather than going to a recognized social agency indicates that they may offer advantages. Which, if any, of these advantages can social agencies make their own without jeopardizing the quality of their adoption work as well as their service to unmarried mothers?

What attracts the unmarried mother to the intermediary? For the unmarried mother the intermediary offers quick service and confidential handling—a hurried protective process which assumes that secrecy is the one kind thing. Speed and secrecy—what enticing bait!

An apparent advantage may be the feeling of approval that a girl gets as the result of being praised for making the "best" plan for her child. It is "best," perhaps, only because it happens to fit in with the plans of the well-intentioned, or well-paid, intermediary.

Moreover, the urgent immediate need for quick return to normal living looms large in the girl's thinking and is seized upon by the unauthorized agency or unthinking intermediary to bring a quick decision to surrender the baby.

Another seeming advantage lies in the fact that the unmarried mother does not have to submit to what she considers "prying" into her life. She does not leave a record behind her which might jeopardize the secrecy of the whole procedure. The whole matter is ended, she believes, when the surrender is made, and there will be no follow-up to disturb her future and to remind her of the whole experience.

Finally, she may receive immediate cash assistance, which she often needs to meet expenses—the adoptive parents paying the bill and the intermediary frequently receiving the lion's share.

What attracts adoptive parents to the unauthorized agency? Again, speed and secrecy.

Who, with experience in adoption agencies, does not know the couple who suddenly decides it would be "just wonderful" to have a baby. Then, there is also the client who rightly complains that he or she has been to an authorized agency and has been waiting now for 2 years—the application is still pending because no child is available, or at least, not the right child.

The intermediary "solves" all such problems expeditiously. No time is consumed with exhaustive study of the personal life of those wishing to adopt a child. They come in for some of the same type of approval that the unmarried mother receives. They are also commended for their willingness to share their home with a child. They may be good people, it is true, but what matters is whether they will be good parents, and particularly, good parents to this individual child.

Do these lures offered by the intermediary have anything that social workers and social agencies should consider? Is it time for social workers to study their own philosophies and procedures? Are social agencies really meeting the needs of people? Or, for want of critical self-analysis, are they allowing these services, calling for highly specialized skills, to fall into incompetent hands?

Actually, social agencies should not only be able to compete with intermediaries but ought to be able to go them one better. If social agencies are not meeting their opportunity and their responsibility right now, the question is, why? Obviously, if social agencies were meeting the need, unmarried mothers would not be turning to intermediaries. Almost any unmarried girl would prefer the agency's protection to the other alternatives, if she knew about them and really understood them.

If social workers are to meet this situation and meet the intermediary on his own ground, they must be willing to say, "We will take this girl regardless of what her circumstances may be—a second baby—a married woman having a baby by another man—a girl without money—a nonresident—all of these girls and women, whatever their circumstances, will be cared for.

How intermediaries fail

Having a baby is a crucial experience—emotionally as well as physically—for a woman, be she married or unmarried. In addition to having the usual emotional attitudes toward pregnancy, the unmarried mother feels anxiety, guilt, and pressure.

As a group, unmarried mothers are frequently emotionally maladjusted, insecure, immature individuals with many conflicts. The crisis of illegitimate pregnancy renders them all the more so. Their future adjustment is jeopardized by the added load of guilt, regret, and anxiety resulting from impulsive, badly advised, hasty decisions. Case-work help at each phase of the unmarried-motherhood experience can reduce its damaging effects on the personality. Adoption without such help fails to provide adequate safeguards.

The plans that are so often made abruptly and quickly through the intermediaries are made at just the time when the mother is least capable of exercising sound judgment in her decisions. A quick decision can be reached verbally and even acted upon, but it may take a lifetime of living with it to resolve it, and it may even prejudice the subsequent adjustment of the person who made it, not to mention the possible detrimental effect on the life of the child. Without leeway to act on a change of heart, particularly on a decision made before the baby's birth, tragic consequences to the mother, the child, and the adoptive parents may result.

The immediate postpartum phase is a most unfavorable time for making valid, important decisions. Nevertheless, because of many pressures—the demand for hospital beds, the urgency of the mother's own need for a speedy solution—the mother is almost blackmailed emotionally into using just that unfortunate moment to make such a vital decision. Vulnerable and threatened because of the predicament created by violating accepted social mores, she is particularly apt to turn frantically for direct advice to friends, family, and other well-meaning—or not so well-meaning—amateurs who are often all too ready to urge a hasty plan upon her.

The unmarried mother should have protection and time—time to work out a decision with the greatest possibility of its being the wisest one for her and the baby, and with a minimum of later destructive repercussions. Not only does she need time, but during it, she should have somebody to whom she can turn for guidance who is objective, impartial, and accepting. Friends and relatives are of necessity limited in their objectivity in such a situation. The trained case worker, on the other hand, is able to meet these needs by offering practical help of various kinds; and at the same time she can assist the girl or woman in finding and carrying out the best plan in the light of her own true feelings and individual situation.

Another very important aspect, largely ignored by an unauthorized person, is the protection of the baby, whose lifelong welfare is at stake. Relief from guilt and ostracism may be won by the mother at the expense of the child's future. Appropriate case work treatment of these mothers in many instances resolves these unconscious conflicts and feelings of guilt and tension without sacrificing the welfare of the baby.

Training and special skill are needed also to evaluate the deeper reasons underlying the decision by couples to adopt a child. The wish to adopt is usually rooted in multiple motives, often contradictory, of different degrees of awareness, and not all are conducive to the best interests of the child or the adoptive parents.

Social agencies must not only concern themselves with what the motives for adoption are but also their relative proportions in a given instance.

In what ways do social agencies fail?

Social agencies need to subject themselves and their procedures to honest self-scrutiny. Do they on occasion exhort the individual seeking help "to be realistic" when in reality it is a rationalization on the part of the worker—an expression of punitive attitudes, conscious or unconscious? Isn't the term "realistic" often invoked as a barricade, shielding the worker from acknowledging inadequate resources with which to meet the client's needs? In such instances, is it not the social agency which is being unrealistic?

Since social workers themselves are products of the culture in which rejecting and punitive attitudes prevail against unmarried mothers and their babies, they need to be especially alert to maintain the objectivity essential to all areas of social work, and to guard against subtle, disguised intrusions of their own needs and attitudes into their professional practices.

Some current restrictive and truly "unrealistic" agency policies arose, and are maintained, to some extent at least, by such hidden penalizing attitudes. For example, there is the girl's frantic desire for anonymity. This is denied her by procedures whereby she is forced to reveal her story in many different quarters. Or an agency fails to recognize the urgency of her needs. An appointment set for 2 or 3 weeks hence to a desperate girl facing an immediate crisis cannot successfully compete with private adoption. Nor can her impatience be branded as "immature intolerance of realistic delay." Rather, agencies must acknowledge that their facilities for emergency care are deficient, and make efforts toward correcting them.

The dilemma of maintaining high clinical standards in the face of pressure for speedier solutions may be met to some extent by learning better diagnostic differentiation among clients so that a wider range of types of help can be offered, based on clinical knowledge of the indications for each. Although all unmarried mothers, in this society, are apt to present personality maladjustment, the degree of this varies enormously.

One type of girl will have greater conflict and mixed feeling entering into all her reactions and decisions and will need more therapeutic help and longer time to work out her plans. Another type of girl, however, less divided against herself and capable of more mature judgment, can reach final decisions more rapidly and may be best served by quicker, more direct, and specifically limited forms of assistance. A girl of the latter type is often driven to independent placement when a social agency mistakenly brushes aside her repeatedly expressed preferences for adoption and persistently emphasizes helping her to "find out what she really wants." It seems almost as important to recognize and accept the capacity for valid self-direction as the lack of it.

Unmarried mothers have in common only the one fact—their illegitimate pregnancy. Otherwise they represent a gamut of personality structures and of socio-economic and educational backgrounds; they differ in race, religion, and temperament, and in clinical psychiatric diagnosis. Such different people need different kinds of help.

If policies become rigidly fixed, without consideration for divergent needs, there is danger that punitive attitudes and procedures will counteract what would otherwise be helpful measures.

Although direct financial assistance to these women is often regarded as a questionable practice, for certain individuals it is undoubtedly desirable. This need for money has particular significance, for in resorting to private adoption, the girl's acute financial plight is often the deciding factor. Case work should be solid enough to determine the need.

Social agencies must consider, too, whether they are really living up to their promises to keep the girl's story secret if she must tell it to half a dozen different people in the course of working out the problem.

For example, in some instances the unmarried mother comes to the emergency desk of the hospital for help; the hospital refers her to the shelter agency; the shelter agency refers her to the department of welfare. Then she is referred to the adoption agency; then to the hospital and the hospital social worker. If there are paternity proceedings she goes to yet another person. If she wants to place the baby in a foster home there is yet another one. Each time she must repeat her story. Upon the girl who is already confused is projected the confusion of the various agencies.

About all social agencies can do to counteract this situation is to make their referrals very clear, prepare the girl for them, and simplify them as much as possible.

The transfer of a baby to an individual or an unauthorized agency for placement occurs about the time that the baby leaves the hospital, and for that reason the role of the hospital in placement is highly important.

The hospitals and their responsibility

Hospitals are beginning to realize that their responsibility and, as a matter of fact, their duty should extend beyond the actual physical or medical care that they render to the mother and baby.

There is, however, a justified criticism of social agencies on the part of doctors—that is their feeling that perhaps too many hurdles and too many obstacles are put in their path, or the path of their patients, in trying to arrange care through the social-service department of the hospital. When the administrator of a hospital questions the social-service department, it becomes obvious that many of these restrictions or obstacles are placed there by the so-called recognized agencies. The administrator is, therefore, still at a loss as to how to expedite the process so that the mothers and babies are well served.

Safeguarding adoption

A vast proportion of the children of unmarried mothers are placed permanently in homes without any of the safeguards that are placed around children who are temporarily placed away from their own homes. What seem to be good procedures for adoptive placement have been carefully worked out by child-placement agencies and yet a vast majority of the children who are adopted do not benefit by these procedures.

One of the first questions has to do with existing legislation and its inadequacy in protecting the child placed independently.

Such a child will be in the foster home before any social agency enters the picture. The investigation, under such circumstances, can only be made with the idea of approving the adoption if it is humanly approvable. Otherwise the only home which the child has really known is disrupted, together with the lives of the foster parents. Once the child has been placed it is too late to deal effectively with such questions as: Is this a child who should be placed for adoption? Is this a home into which a small child should be placed? Is this the home for this particular child? Social agencies are handicapped in answering such questions if they look into the home 6 months or a year after the placement. Their investigations, their judgments, are made when it is too late for them to be real judgments.

Some States are beginning to grapple with the problem and are trying to meet it. In many States there is no legal requirement to safeguard the child, the natural parents, or the foster parents.

The time has come when States should look at this whole situation and see what kind of legislation can be helpful to secure certain safeguards for everyone concerned.

Definitive solutions to this complex problem have not as yet been attempted. However, social workers are the professional group most competent to assume responsibility for leadership in social planning and practice in this field of adoption.

As the public understands the weaknesses of the service offered by intermediaries, profiteers, and traffickers in this field, it will tolerate them as little as it does incompetent practitioners in medicine and law.

Within the professional fields themselves, the need for recognizing and separating out the specific contribution of each professional group involved is apparent. These groups must be encouraged to pull together toward safer adoption practices. If medicine, law, hospital administration, and social work will each study means for improving its own part of this work, this goal will be relatively easy to achieve.

A more complete report, 36 pages mimeographed, may be obtained at 25 cents a copy from the office of the Welfare Council of New York City, 44 East Twenty-third Street, New York City. For 10 or more copies the charge is 20 cents each.

HELPING THE HARD-OF-HEARING CHILD

Crippled children's agencies plan new services to give these children a better chance

by *ARTHUR J. LESSER, M. D.*

Health Services Division,
U. S. Children's Bureau

● **EVENTS OF THE PAST** few years have led to considerable emphasis on the national problem of handicapped persons. The results of the physical examinations made by selective-service boards have brought into prominence facts about the health of our youth which have been more or less generally known but which have acquired a new importance because of their relationship to the requirements of national security.

Hearing tests alone insufficient

Interest in the child with impaired hearing was stimulated a few years after the First World War by the development of the "4–A" audiometer, which facilitated the testing of children in groups. School systems, especially in the cities, have developed procedures for the periodic testing of school children and for evaluating special educational requirements for them. In some of the city-school health programs provision is made for the examination of selected children by an otologist. The inadequacies of programs of this type lie chiefly in the failure to provide for the medical care and the rehabilitative measures that may be needed.

The shortcomings of case-finding surveys which do not provide for remedial services are well illustrated by a recent study of the school health-examination records of a group of men rejected for military duty.(*1*) This reveals that a relatively large number of the defects causing the rejections had been present in childhood and had been noted on the school records. Many of the defects were of the kind that are preventable or could have been corrected. This exemplifies a common situation in our school health programs—an emphasis on the discovery of defects but a lack of effective planning to correct such defects or prevent their progression.

Surveys of hearing tests show that 4 to 6 percent of school children have impaired hearing. Six percent is the figure arrived at in a recent statistical review of such tests, including 1,079,168 pupils in 30 States tested by the group audiometer during a school year.(*2*)

There are a few indications that defective hearing is more extensive in rural than in urban areas. A hearing survey in Minnesota revealed that about 14 percent of an unstated number of rural school children had a significant hearing loss as compared with 5 percent of Minneapolis school children of the same age, with the same technique of testing employed.(*3*) In Delaware, among 1,386 children attending rural schools having from one to four teachers, 11 percent were found to have a significant hearing loss, compared with an incidence of 6 percent among 10,100 Wilmington school children.(*4*)

A concern of every community

Regardless of variations reported in the incidence of hearing impairment, enough facts are available to show that this is a serious problem affecting children in every community, a defect that is frequently progressive and which affects the child socially, psychologically, and financially as well as physically. Since much hearing loss is preventable, it is pertinent for us to ask what is being done in our communities to prevent deafness and to care for children who have a loss of hearing. It is obvious that if a program of hearing testing is to be of more than statistical value, it should be regarded as only a preliminary step toward establishing a comprehensive plan for the medical care, education, social adjustment, and general rehabilitation of children who are found to be handicapped.

The remedial problems of many children with loss of hearing are complex and often frustrating. For some hard-of-hearing children medical treatment can accomplish little, and emphasis must be directed toward general rehabilitation. These difficulties have recently been somewhat obviated. The development of more efficient hearing aids has made it possible to provide improved hearing for many children in need of help. The dramatic results in therapeutics being achieved with the sulfonamide group of drugs and penicillin in controlling infections of the ears that often result in impaired hearing have been a prominent factor in vitalizing interest in the prevention of deafness.

Hope for prevention of deafness

It is, after all, in the prevention of deafness that our greatest hopes lie, and now medical resources are available which make it possible to implement effectively an educational campaign for prevention.

Here is a group of children in whose welfare interest is widespread. Scientific methods of locating them are in general use, better appliances for providing improved hearing for many are available, methods of speech conservation and of instruction in lip reading have been developed in the schools, and medical measures for the prevention of much hearing loss now appear to be a reality. The methods therefore are now available by which a comprehensive program for the hard-of-hearing can be developed.

Such a program, of course, requires the cooperative efforts of public and private agencies in various fields, such as State and local departments of health, education, and welfare, and societies for the hard of hearing. It is probably best developed as part of the State crippled children's program, in a local area with an organized health department, where it is possible to make provision for medical and hospital care, public-health nursing, medical-social services, and general rehabilitation. It should be conducted in cooperation with the educational authorities.

The largest source of cases will be found in the schools through hearing tests. In communities where periodic testing has been done, many hard-of-hearing children will already be known to the schools. In testing the hearing of school children, it is desirable to include the retesting of pupils in the schools for the deaf, since children may be found in these schools who can attend regular schools if properly fitted with hearing aids and taught lip reading. Of course, preschool children will not be reached by school testing, and therefore reliance must be placed on referrals from other sources, particularly public-health nurses and parents. This is an important group to reach inasmuch as preschool children are often more adaptable to their handicap than older children and, moreover, impairment of hearing often occurs early in life and affects adversely the development of speech.

Federal-State programs begun

The Children's Bureau is now cooperating with two State crippled children's agencies in developing programs for children who have impaired hearing. Owing to limited funds only a few localities in these States are being served.

Medical services in the Federal-State programs are provided by qualified otologists in clinics conducted by the official State agency, and in hospitals. In addition to the otological examination individual hearing tests are performed. Provision is made for whatever treatment is needed, whether in the clinic or in the hospital. It should of course be hardly necessary to point out that in any specialized service a thorough general pediatric examination is essential.

One of these programs is giving particular attention to a group of children whose hearing deficiency is believed to result from secondary changes in the middle ear following obstruction of the Eustachian tube. Examination of the area around the opening of the Eustachian tube often reveals an overgrowth of adenoid tissue, which may obstruct the opening of the tube. If this is not treated, the hearing may become impaired. Treatment of the adenoid tissue by a radioactive substance called radon usually reduces the mass of adenoid tissue. A study is being made in this program of the incidence of this condition in causing hearing impairment and of the efficacy of radon in preventing loss of hearing.

Clinics for the hard-of-hearing

A clinic for hard-of-hearing children, particularly if serving a rural area, will usually be found to supply a long unmet community need. Indeed, in one of the programs it has been difficult for the clinic to meet the many requests for services coming from public and private agencies and from referring physicians. A large number of the children being referred to this clinic have varying types of nose and throat conditions which may have only a remote relation to hearing. This program has demonstrated, in an average rural county in the East, how well received is a highly specialized service of this type. Obviously, the need for this service in this country is great, dealing as it does with a variety of conditions which are largely subacute or chronic and which present obstacles both to treatment and to rehabilitation. The condition that leads to impairment of hearing often causes no serious discomfort and may lend itself to adjustment by the person, but frequently progresses until a disabling condition has been established.

The clinic or health center also serves as the center for an educational drive among the public, the schools, and the medical profession against loss of hearing. The prospects of preventing much of the hearing loss that results from infections such as otitis media, mastoiditis, and meningitis appear to be good. The recent remarkable results achieved in controlling infections by the use of the sulfonamides and penicillin will probably effect a considerable reduction in the number of children who have lost their hearing as a result of ear infections. The widespread use of these drugs has resulted in a considerable diminution in the number of children developing mastoiditis and chronic otitis media. There seems to be no doubt that good medical care in acute otitis media will prevent the development of a large percentage of new cases of deafness annually. However, the weekly or monthly otology clinic alone cannot accomplish this. The responsibility for this must lie with the family, the schools, and the community in recognizing the importance of prompt medical treatment of acute otitis media. The preventable nature of certain types of deafness must be emphasized and the information widely disseminated. Here the role of the public-health nurse is of utmost importance in view of her knowledge of family situations and her repeated visits to families and conferences with teachers regarding their pupils.

Needs of various children

Some children should be fitted with individual hearing aids by an otologist or a qualified assistant. For many the regular school program should include speech conservation and instruction in lip reading, given by special teachers under the general guidance of local and State educational authorities. Many State and city school systems now have departments of special education, one of the responsibilities of which is to plan and direct adjusted educational programs for handicapped children, including those with defective hearing.

Speech conservation and instruction in lip reading are important even for children with a mild degree of hearing loss. In fact, when hearing becomes impaired some children automatically begin to watch the movements of people's lips as an aid to hearing. This natural tendency should be guided by training. Whether training in speech and lip reading alone will suffice or whether this training should be given in conjunction with the use of a hearing aid will depend on the degree of hearing loss. This decision requires a careful and detailed evaluation of the child's disability and of his accomplishments in speech and hearing.

In many cases provision of hearing aids and instruction in lip reading will not be enough. Older children particularly are apt to have great difficulty in accepting the fact that their hearing is permanently impaired and that a measure of restoration can be found only through wearing an appliance. The seriousness of many adolescent children's reaction to the information that nothing further can be done to restore hearing must not be underestimated. For many the psychological impact is as serious as that occurring in cases of blindness. For such children this is the point at which the program can be considered a success or a failure. It will tax the skill and patience of the physician, and of the child's teacher, the public-health nurse, and especially of the medical-social worker to help these children in accepting their handicap and making a good adjustment to it. Resistance to wearing the hearing aid sometimes may be one manifestation of a more general problem in adolescent personality adjustment. In such instances the help of a child psychiatrist often proves most valuable. Working with the parents becomes just as important, for they must be assisted in overcoming their fears with regard to the child's school and social adjustment and his future capacity to be self-supporting.

Start restoration measures early

The feeling of inadequacy and the emotional conflicts encountered among adolescents with impaired hearing can be largely prevented by starting restoration measures early in childhood whenever these are needed. The delight and enthusiasm that young children display when they are assisted in hearing by an aid is often in sharp contrast to the reluctance to use an aid shown by older people. Much of the trouble in school, the repeating of grades, the problems with other children, which constitute tragedies in hard-of-hearing children's lives, may be avoided by early treatment.

Instruction of young children in lip reading and the use of hearing aids has permitted many who have severe hearing loss to progress normally in regular schools. Segregation of deafened children in special schools is necessary only for comparatively few. Efforts should be made to assist the child so that he can attend school with normal children, since most handicapped children progress better and are happier when they can associate freely with normal children. The value of hearing aids for young children probably has not been fully realized, but if children are to make the best use of the degree of hearing left them, more extensive use of aids and lip reading in properly selected cases is essential. This will give many of these children equal opportunities with others in schools and in adult life.

(*1*) Ciocco, Antonio, Henry Klein, and Carroll E. Palmer: Child Health and the Selective Service Physical Standards. Public Health Reports, Vol. 56, No. 50 (December 12, 1941). Pp. 2365–2375.

(*2*) Berry, Gordon, M. D.: Deafness in the United States; a statistical review. Volta Review, Vol. 40, No. 2 (February 1938), pp. 69–71; 120.

(*3*) Hearing Problems in Education, by Horace Newhart, M. D. Journal of the American Medical Association, Vol. 109, pp. 839–841 (September 11, 1937).

(*4*) An Investigation of the Acuteness of Hearing of Children in the Delaware Public Schools by Means of the 4–A Audiometer (Phono-Audiometer), by Virginia S. Wallin and J. E. Wallace Wallin. Board of Education, Wilmington, Del. Processed. 64 pp.

Reprints available on request.

JOHNNY'S TEACHER is testing his hearing with an individual audiometer. He has previously been tested with his classmates by means of a group audiometer, and the group, or screening, test showed that his hearing was impaired. The individual test will give a much better idea of the extent of Johnny's hearing disability and what help he needs.

Photograph by Look Magazine

Photograph by Look Magazine

COUNSELING YOUNG WORKERS

by *JANE F. CULBERT*

Vocational Advisory Service
New York City

• **GOOD VOCATIONAL** counseling is always personal; it never loses sight of the many-sided individual who is seeking advice, nor the fact that it is dealing with a growing, developing human being.

No set of rules, no equipment will enable a counselor to assign a person automatically into one or another vocational niche. Though the beginning worker may be one likely to do well in certain kinds of jobs because, for example, he has excellent finger dexterity, or facility with numbers, he may have so much more interest in another line of work that it would be unwise to urge him into a field to which he brings less interest. The good counselor knows that most people have a sufficient variety of abilities to succeed in more than one line, and that a man's greatest ability multiplied by little interest may not bring so high a product as his maximum interest multiplied by his second or third set of abilities.

Ability to understand the individual, to find out who he really is, to help him express his interests, aims, and hopes, and to evaluate them, is a primary requisite of the good counselor.

Wide background needed

However, he must also have a wide background of information and experience so that he may be able to see where the young person could utilize his interests. He must know the demands made in various fields of work, and be able to judge whether the environment of a certain line of work would be congenial and to evaluate the suitability of a given type of work for a specific individual, and also to take into consideration the background of each individual, if he is to do more than give information about work fields or training.

A good counselor uses all practical aids to understanding the person that are provided by the community. He will maintain active relationships with community agencies, for both the information that they supply and the service that they render, to supplement the social and recreational life of young people who need development along these lines to help them achieve a satisfactory personal life and to add to their employability.

The counselor will need to be in touch with such agencies as the employment service and with the chamber of commerce or local business groups, in order to keep abreast of employment changes and opportunities.

Aptitudes not only factor

Psychological tests will be used by the counselor, whether these are given through his own agency or through other community resources. He will make sure that tests are reliably and professionally given and that they are properly interpreted. Moreover, he will use the interpretations of these tests only as one source of important information about the individual's abilities, since, as has been suggested, interests, personality, and other factors, as well as many practical considerations, are important along with aptitudes.

A good counselor will help the young worker to understand the situations that he will find in beginning jobs and the way in which he may draw from even limited situations information that will be valuable to him later.

It is more important in beginning placements than in those for experienced workers that the placement be made with a view to the young person's social and personal limitations, needs, and strengths. Of two young people, each with the same kind of clerical ability, one may be very happy working alone in an office, with responsibility for a certain set of routine tasks; while another will be discouraged from all clerical work unless the job provides some companionship and a variety of duties.

The experienced worker can see how he fits into the whole organization, and can see possible lines of advancement, where the young worker cannot.

No matter how experienced, the counselor will not expect to know everything about the occupations and training resources applicable to a given situation, nor yet about the young person before him. He knows that it is no reflection upon himself if he cannot give immediate answers to all the questions that are raised, either about the occupations under discussion or their suitability for the applicant at the moment.

When dealing with adolescents, he will always keep in mind that he is dealing with enthusiasms that may shift again and again in quick succession. Though these may not safely be regarded as direct indications of future vocations, they must be seriously considered as clues to the type of work, activities, or social and emotional needs which must be represented in the plan if it is to be accepted and if it is to "take." Good counseling ordinarily does not assume a final answer for the young person. Rather, it gives a sense of direction and opens possibilities.

A good counselor will have the habit of reflecting upon the problem, taking time to see the relationship between the various factors that enter into it, and being sure that his advice is in line with the young person's development and is not merely an immediate answer, which, taken alone, might lead him astray.

Finally, good counseling cannot be done on a mass basis. The experienced counselor knows that hurried or superficial work is not sound, either for the applicant or for the agency, and will therefore not accept more cases than he can handle adequately, even though some young workers will have to do without his services.

Miss Culbert writes from many years' experience as director of the Consultation Service, a vocational-counseling service for young people conducted jointly by the Vocational Advisory Service and the U. S. E. S. Employment Office in New York City.

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CHILDREN'S BUREAU • U. S. DEPARTMENT OF LABOR

- HANDS ACROSS THE BORDER
- CHILDREN IN OTHER AMERICAN REPUBLICS
- MIGRANTS' CHILDREN NEED DAYTIME CARE

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The photograph on the cover, of boys and girls playing after school at a child-care center for children of migratory farm workers, was taken for FSA by Rothstein.

U. S. DEPARTMENT OF LABOR
L. B. Schwellenbach, *Secretary*
CHILDREN'S BUREAU
Katharine F. Lenroot, *Chief*

LATIN AMERICA AND THE CHILDREN'S BUREAU

For the past 30 years the Children's Bureau has been cultivating friendships and promoting joint effort for the welfare of the children of the Americas. Its activities are included in an inter departmental program of the United States, which is part of the foreign policy of our country.

The foundation for much of the Bureau's work in inter-American matters has been laid through the Pan American Child Congresses, of which eight have been held. The most recent of these congresses met in Washington in 1942 and adopted a Declaration of Opportunities for Children, which has been widely used throughout the hemisphere. Continuing inter-American child-welfare activities are carried on through the American International Institute for the Protection of Childhood, which has headquarters in Montevideo. The Ninth Pan American Child Congress is scheduled to meet in Venezuela, probably within a year.

One of the important inter-American events which have strengthened the basis for international cooperation in behalf of children was the Inter-American Conference on Problems of War and Peace, held in Mexico City a year ago.

The conference recommended that all the American Republics adhere and give full support to the American International Institute for the Protection of Childhood and to other inter-American organizations working for the welfare of the people of the American Republics.

It recommended also that the governments encourage the further development of inter-American activities on the part of public and private organizations and associations of a national character.

In another resolution it was recommended that an extensive study be made of all aspects of family life and of the problems of women and children in the American Republics. Plans for this study are being developed.

Some of the ways in which the governments and citizens of the American Republics are working together in behalf of the children of the Western Hemisphere are portrayed in this number of *The Child.*

Direct cooperation in carrying out parallel programs of joint concern is illustrated by the account of the visits of child-labor officials from Mexico and the United States in communities along our common border.

The growth of a comprehensive program of interchange of knowledge and skills between the United States and her sister Republics of the New World is described in the article by the Director of the Children's Bureau Inter-American Cooperation Unit. January 1946 marks the fifth anniversary of the establishment of this Unit.

Through inter-American conferences, such as the First Pan American Conference of Social Service, described in another article, experience is exchanged, lasting friendships are formed, and the stimulation and inspiration of fellowship in a common endeavor give impetus to new growth.

Advances in individual nations, many of which have attached great emphasis to the provision of fuller protection and opportunity for all children, are illustrated through brief news notes.

Our inter-American experience should contribute to the development of world-wide cooperation that will help to cement the bonds between nations so as to assure lasting peace.

Katharine F. Lenroot

Katharine F. Lenroot,
Chief, Children's Bureau.

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HANDS ACROSS THE BORDER

Child-labor officials from Mexico and the United States visit each other's countries

by *GWEN GEACH*

Regional Child-Labor Consultant
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U. S. Children's Bureau

● On both sides of the Mexico-United States border live thousands of workers' families of Mexican heritage. In both countries many of these families face the same conditions—poverty and the resulting child labor, illiteracy, bad housing, disease, and neglect and delinquency of children and young people. And in the United States they face also the barrier of a strange language.

Some beginnings have been made by representatives of the governments of both nations in struggling with these families' problems, which are so much alike in the border States of the two countries. A long step toward success in this struggle was taken when health officials of both countries joined to form the United States-Mexico Border Public Health Association. This group has met annually for the past 3 years and expects to meet again this year, to deal with health problems in the border States. The work of the association, through its contributions to the solution of common health problems of the border States, has led to better understanding between professional workers in the two countries.

Preparing for the conference

Early in 1945 the Chief of the Children's Bureau visited Mexico to attend the Inter-American Conference on Problems of War and Peace as an adviser to the United States delegation. At the time of this visit Miss Lenroot discussed with Mexican officials the agenda of the 1945 meeting of the Border Health Conference, especially the possibility of taking up the subject of maternal and child health and child welfare.

Partly as an outgrowth of this discussion the 1945 conference, held in May, included a round table covering a broad range of problems affecting children.

The conclusions of the round table suggested various fields for cooperation in planning ways in which children on both sides of the border might have the protection and the opportunities necessary for their best development, and recommended, among other measures, "observation and study by professional workers in Mexico and the United States."

Exchange of visits arranged

Soon after the conference the Chief of the Children's Bureau and the Chief of Mexico's Office of Women and Minors discussed the possibility of carrying out the recommendation concerning observation and study in the two countries by arranging for exchange of visits by child-labor law-enforcement officials.

The result of this discussion was a plan for two child-labor law-enforcement officials representing Mexico and two representing the United States to go together to selected parts of each country to observe the techniques used there in enforcing child-labor laws, especially the issuing of employment certificates and the inspection of factories.

The representatives of the United States were both staff members of the Industrial Division of the Children's Bureau, engaged in enforcing the child-labor provisions of the Federal Fair Labor Standards Act of 1938. The Mexican representatives were both on the staff of the Office of Women and Minors of the Federal Department of Labor.

The United States officials selected the border States of Texas and New Mexico for the visits by the Mexican officials. The cities were Austin, San Antonio, and El Paso in Texas, and Santa Fe and Albuquerque in New Mexico. The representatives of Mexico selected the State of Nuevo Leon, and the visits were made in the city of Monterrey in that State.

Observe certificating procedure

About the middle of September the two Mexican officials arrived in Austin, Tex. In this city the visitors observed the procedures followed in issuing Federal cer-

HOUSING CENTER in the Mexican section of San Antonio. The children have more play space than most Mexican youngsters in cities on either side of the border.
Photo by FPHA

tificates of age. (Texas is one of the few States where certificates of age in connection with enforcement of the Fair Labor Standards Act are issued by the Federal Government. The State of Texas does not have a system, as many other States have, that can be used for this purpose.)

In Austin also the Mexican visitors had the opportunity to observe enforcement of a State child-labor law, when they accompanied a State factory inspector on inspection visits to a drug store and a bowling alley, places not covered by the Federal law.

Child-labor inspections by Federal officials were the next activities observed by the Mexican visitors. In San Antonio and El Paso, Tex., and in Albuquerque, N. Mex., visits were made to establishments covered by the Fair Labor Standards Act. These included garment factories, a cotton mill, and a lumber yard. In each of these cities the visitors went to the selected establishments with an inspector from the local office of the Wage and Hour and Public Contracts Divisions of the United States Department of Labor.

In Albuquerque, New Mexico's State employment-certification system was observed by the visitors. The official who issues the certificates is also a visiting teacher, and she and the school-attendance officer and the student counselor explained the work they were doing in the interest of teen-age boys and girls.

Photo for Three Lions by Severin

JUAN is finishing a good lunch at school. But many children of Mexican heritage on both sides of the Mexico-United States border get little food at home to eat.

Discussion of border problems

In both Texas and New Mexico the visitors discussed many problems concerning children and young people on both sides of the border. In New Mexico they talked with State labor, education, welfare, and health officials; also with the Director of the School of Inter-American Affairs, University of New Mexico, and the Archbishop of Santa Fe. In Texas they met with the executive secretary of the Governor's Good Neighbor Commission, the local representative of the Office of Inter-American Affairs, representatives of organized labor, the Archbishop of San Antonio, and the Director of the Mexican-Christian Institute.

The representatives of Mexico spent an evening visiting this institute, one of the low-cost housing centers in San Antonio. The center has, besides housing units, a central community building in which is located the center's office, meeting rooms, a sewing room, a maternal and child-health clinic, a nursery, and a library. The center also has two playgrounds, one for little children and one for older boys and girls.

In contrast to the housing center, a number of inadequate and insanitary dwelling places were observed by the visitors in this section of the city, through which they were escorted by two public-health nurses from the San Antonio Health Department. In this section, according to the director of the city health department, the number of deaths of children and young people is extremely large. The director told the visitors about the department's efforts to combat the diseases prevalent in this section and described the city's recent educational campaign for control of diarrhea. (For an account of this campaign see *The Child* for July 1945.)

Border cities in pairs

In their interviews with public officials and civic and religious leaders, the Mexican visitors learned of many acute problems affecting children and young people in the pairs of towns on the opposite sides of the border, such as Brownsville and Matamoros, Laredo and Nuevo Laredo, and El Paso and Juarez.

These pairs of cities are connected by bridges across the Rio Grande, and hundreds of men, women, and children cross into the opposite town daily, to work, to shop, or to visit relatives. They travel by street car, by bus, or on foot.

To be permitted to cross into the other country it is necessary only to carry a "bridge card," which shows the nationality and identity of the holder. A person who wishes to use such a card obtains it from Federal authorities on his own side of the bridge. The cards are good for a long time.

It is easy also to enter each country illegally by wading, swimming, or rowing across the Rio Grande.

Such easy access to another country by children and young people creates many problems for officials enforcing child-labor, school-attendance, and other laws. And along with easy accessibility of a city in another country goes the problem of dual nationality. A child born in the United States is, according to our law, a citizen of this country. If, however, such a child's parents are citizens of Mexico and the family lives in Mexico, he is considered by that country to be a citizen of Mexico.

Joint action needed

If an official enforcing the child-labor or school-attendance laws questions a child on the street or at work the child is likely to say that he does not live in this town and therefore is not subject to the laws in force in the town or State. For example, an official enforcing the school-attendance law in El Paso might question a child on the street and learn from him that he is not a resident of El Paso but lives across the border in Juarez. Such a child is therefore not subject to the school-attendance laws of Texas. The same child, if later questioned in Juarez by Mexican school officials, may state that he is a citizen of the United States of America. Only by joint action can such problems as this be dealt with successfully.

Excellent factories

When the United States officials visited Mexico they observed Federal factory-inspection procedures in Monterrey in the State of Nuevo Leon. With a Federal inspector they visited five plants; two were garment factories and the other three manufactured respectively cigarettes, electric lamps, and glass.

The glass factory, which has 11,000 employees, was of great interest. Very little of the blue glass usually associated with Mexico was being made there. Ordinary glass tumblers, bottles, water jugs and jars, vases, lamp globes, cups and saucers, and plates were being made, as well as hand-decorated and etched wine glasses, cocktail sets, bowls, and table ornaments. In one room of the factory handmade glass was being manufactured. Here, in three tiers around a furnace were three-man teams, swinging a ball of molten glass on the end of a pipe and turning and blowing it into objects of art.

The visitors found some of these plants excellent in construction and layout.

The work rooms were well-ventilated and well-lighted; and lunch rooms, clinics, and rest rooms were provided.

The owner of a less adequate plant explained that the establishment was moving to a new factory building shortly.

Federal inspection in Mexico is done only in industries covered by a "contracto ley," or code. Establishments in other industries are inspected by State officials. A code is drawn up by representatives of employers, of employees, and of the Department of Labor. A request for a code may be made either by employees or by an employer.

Codes cover the production of textiles, metals, oil, sugar, rubber, lumber, porcelain, and motion pictures; the fishing industry; communication industries; and some others.

The United States visitors learned that before the war the minimum wage for the workers in industries covered by codes was the equivalent of 50 cents a day. During the war as an emergency measure this minimum was raised to 72 cents a day.

Working hours of adults are limited by law to 8 hours a day and 48 hours a week. The law requires that the workers be paid for 7 days' work a week, even though the workweek is limited to 6 days.

Legal restriction on child employment

According to the law, children as young as 12 years of age may be employed, but children under 16 may not be employed in any dangerous, unhealthful, or immoral occupation, and their working hours may not be longer than 6 a day; they must not work before 6 a. m. or after 8 p. m.

Other employment conditions that were explained to the United States officials were as follows:

No child under 16 may sign a wage agreement. Such an agreement is made for him through a labor union, unless there is none for the plant concerned; in this case the agreement is made through a parent or tutor.

No employment certificates are issued in Mexico. The employer is responsible for accurately determining the age of workers who are minors.

The most flagrant use of children as workers occurs in street trades and in establishments not covered by codes.

Child-labor inspection

If a plant is inspected and is found in violation of the law a copy of the inspection report is given to the employer, and after a short time another inspection is made. If on the second inspection the employer is found to be violating the law, this report is turned over to the legal branch of the Federal board of conciliation and arbitration. The employer is then called before the board, which hears the case and sets the fine. If the employer refuses to pay the fine the case is taken to court.

Some of the questions that the Mexican inspectors asked the employers were of special interest to the visitors from the United States: Have periodic medical examinations, for instance, been given to the workers? Are the workers paid for the seventh day of the week (the rest day)? Is there a union in the plant? What percentage of the employees are Mexicans? (The law requires that 90 percent must be Mexicans.)

In all the conferences the Mexican officials displayed great interest in improving the conditions of the working people and in carrying out President Avila Camacho's policy that all Mexicans be taught to read and write. They showed pride in the new public schoolhouses and playgrounds that had been built. They seem to see in public service a way of helping people find a way of helping themselves.

TO PROMOTE CHILD WELFARE IN OTHER AMERICAN REPUBLICS

Children's Bureau gives advisory service to children's agencies on their request

by *ELISABETH SHIRLEY ENOCHS*
Director, Inter-American Cooperation Unit, U S. Children's Bureau

● Since 1941 the Children's Bureau has included a unit known as the Inter-American Cooperation Unit, through which a staff of medical, nursing, nutrition, and social-service consultants gives advisory service, on request, to official maternal- and child-welfare agencies of the other American Republics and which directs programs of study, observation, and in-service training for specialists in these fields, invited to the United States.

Association of the Children's Bureau and agencies of our sister Republics had its genesis many years ago. As early as 1916 Julia C. Lathrop, the Bureau's first Chief, made efforts to obtain representation of the United States at the First Pan American Child Congress, organized by a group of women in Buenos Aires, Argentina. Consultation service was given to many specialists from the southern Republics who visited the Bureau in Washington. Miss Lathrop and her successor, Grace Abbott, conferred with many such specialists in Geneva in connection with the work of the Advisory Committee on Social Questions of the League of Nations. Correspondence and exchange of literature developed through the years, and attendance at the various Pan American Child Congresses furnished opportunity for cooperative planning for the children of the Western Hemisphere.

In 1938 an official representative of the Children's Bureau of Brazil spent several months in Washington making a thorough study of the organization and functions of the United States Children's Bureau, and in the same year the Chief of the Children's Bureau, Katharine F. Lenroot, was invited by the Government of Venezuela to attend the First Venezuelan Child Congress in Caracas as its special guest.

Ten years earlier, in 1928, the United States gave its formal adherence to the American International Institute for the Protection of Childhood, the official Pan American child-welfare agency, which had been established the previous year in Montevideo, Uruguay, as the result of recommendations of various Pan American Child Congresses. Miss Lenroot was appointed by the Department of State as the official representative of the United States on the International Council of the Institute and has continued to serve.

These are but a few examples of the type of cooperation carried on in the past, which provided a basis for the program now directed by the Inter-American Cooperation Unit.

Laws authorizing program

This program has its legal basis in two acts of Congress, namely, Public Law 63, approved May 25, 1938, and amended May 3, 1939 (53 Stat. 652) providing for the temporary detail of United States Government employees to the other American Republics, the Philippines, and Liberia, with all or part of the expenses paid by the country desiring aid; and Public Law 355, approved Aug. 9, 1939 (53 Stat. 1290), which authorizes the President to use the services of departments, agencies, and independent establishments of the Government in carrying out the reciprocal undertakings and cooperative purposes stated in the treaties, resolutions, declarations, and recommendations signed by all the 21 American Republics at inter-American conferences.

As a result of this legislation an interdepartmental committee was organized to operate under the auspices of the Department of State. This is the Interdepartmental Committee on Cultural and Scientific Cooperation, composed of representatives of 22 Government Departments and agencies. At the request of Congress the Department of State presents the budget estimates for the inter-American projects of all these agencies, and the funds are then allocated to them by the Department of State from its appropriation.

Congressional committee reports

In 1941 a congressional committee toured South and Central America on an official trip, examining Federal activities. The committee reported as follows to the chairman of the Appropriations Committee of the House of Representatives:

> The various projects that are being carried on, at a relatively modest cost, in Latin America by representatives of numerous agencies of our Government may be regarded, generally, as efficacious and productive of results. For example, the Coast and Geodetic Survey is assisting certain governments in setting up technical and administrative machinery for prediction of tides and for gravity surveys. The Children's Bureau is giving counsel in the matter of the progress that has been made in this country in the field of maternal and child health . . . Groups of students and professors are being exchanged . . .

The words "at a relatively modest cost" might have been written with the Children's Bureau in mind, for the first allocation of funds from the Department of State for this Bureau totaled $7,500. For the fiscal year 1946 it is nearly $71,000.

As an official request had already been received from the National Children's Agency of Brazil for consultation on plans for development of social services for children in some of the States of that country, a pediatrician and a social worker were assigned to Rio de Janeiro to carry out the first cooperative project. This year finds the Children's Bureau again cooperating with its sister agency in Brazil through the assignment of a child-welfare worker, part of whose salary is being paid by the Brazilian Government under the provisions of Public Law 63.

The years since 1941 have found the staff of the Inter-American Unit cooperating with the Ministry of Health in Paraguay in the development of plans for a Department of the Child and in training professional staff for maternal and child-health work; with the Ministry of Labor, Health, and Social Welfare of Colombia in studying the needs of dependent and delinquent children; with the Ministry of Labor, Health, and Social Welfare of Bolivia in revising the Children's Code; and with the staff of the American International Institute for the Protection of Childhood, in Montevideo, in developing plans for advisory service in the field of social welfare. The interest of the American republics in training professional staff for children's services has led to the assignment of several members of the unit to cooperate in establishing or strengthening schools of social work or to cooperate in the training of nurses for maternal- and child-health agencies. During the year 1944 a pediatrician, a public-health nurse, a social worker, and a nutrition consultant were assigned to special cooperative projects in Peru. Cooperative undertakings are also under way in Ecuador in connection with the establishment of a school of social work and in the Dominican Republic, where great progress is being made in the development of maternal- and child-health services.

In 1942 the Children's Bureau invited six specialists to the United States for periods of study and observation. In 1945 nine specialists were invited for special training in maternal and child health and child welfare. All were members of an official agency in Brazil, Colombia, Costa Rica, Dominican Republic, Ecuador, Nicaragua, Paraguay, Peru, or Venezuela.

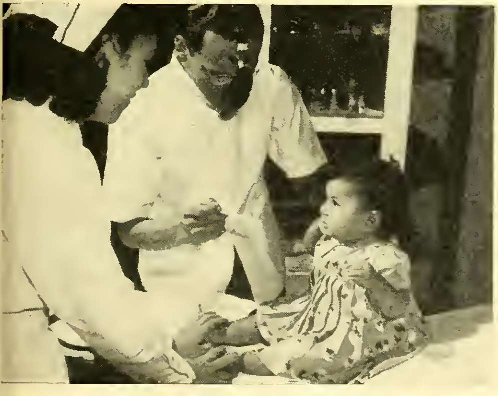
No one-way road

The Appropriations Committee has stated its conviction that "the cooperative purposes enunciated in the treaties, resolutions, declarations, and recommendations unanimously adopted at the Buenos Aires and Lima Conferences, on which this program is based, are of a very worthy and lasting nature and should be continued and in time expanded." It has likewise warned that, "We must not make a one-way road out of the program," since "It is equally as important that we acquaint ourselves with the life, government, traditions, culture, and thought of our Latin-American friends as it is for us to provide facilities for them to become acquainted with ours." The State Department reports that during the fiscal year 1944 the governments of the other American Republics contributed approximately a million dollars more to this program of the various cooperating Federal agencies than did the United States. However, the results of such a program cannot be measured alone in dollars and cents. The members of the staff of the Inter-American Unit who have been cooperating with the other American Republics since 1941 have brought back to the Bureau a wealth of information and experience. At the same time, one of the Bureau's Latin guests has expressed his opinion of the Bureau's program in the following unduly generous terms:

> In this hour of world organization, I have more faith in the Children's Bureau and its international work for the benefit of the child in all places, than in Dumbarton Oaks or San Francisco. After all, the latter, in fact, depends upon a human factor, while the Children's Bureau works on the human factor itself, from its early roots, from its first hours of life.

CATALINA is just a bit doubtful as the doctor at the clinic at Santa Tecla, El Salvador, prepares to examine her throat.

C. I. A. A. Photo



LITTLE PEDRO and his mother are waiting for the physician at one of the clinics for mothers and children in El Salvador.

C. I. A. A. Photo

QUOTE—UNQUOTE

President Truman calls health of children a public responsibility

"The health of American children, like their education, should be recognized as a definite public responsibility."

"A preventive health program, to be successful, must discover defects as early as possible."

"We should, therefore, see to it that our health programs are pushed most vigorously with the youngest section of the population."

"We are a rich Nation and can afford many things. But ill health which can be prevented or cured is one thing we cannot afford."

"It is more important [than to search the past in order to fix the blame for the physical and mental defects of rejectees] to resolve now that no American child shall come to adult life with diseases or defects which can be prevented or corrected at an early age."

"We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation."

"We are only beginning to realize our potentialities in achieving physical well-being for all our people."

"No area should be without community health services such as maternal- and child-health care."

"Hospitals, clinics, and health centers must be built to meet the needs of the total population and must make adequate provision for the safe birth of every baby and for the health protection of infants and children."

"The emergency maternity and infant-care program for the wives and infants of servicemen—a great wartime service authorized by the Congress—has materially increased the experience of every State health agency and has provided much needed care."

From President Truman's message to the 79th Congress, November 19, 1945

Pope Pius XII asks the world to help children who are victims of war

"But of the almost countless ills born of the dire struggle none so hurts or so wounds our paternal heart as that which involves a host of innocent children, millions of whom it is estimated are in many countries without the necessities of life and are suffering from cold, hunger, and disease. Often, too, in their utter dereliction they feel the want not only of food, clothes, and shelter but also of the affection which their tender years so need."

"Let all remember and reflect that these children will be pillars of the next generation and that it is essential that they grow up healthy in mind and body if we are to avoid a race infected with sickness and vice. Nobody should hesitate, then, to contribute time and money to a cause so opportune and essential. Those who are themselves less wealthy should give what they can with open hand and willing heart. Those who live in luxury should reflect and remember that the indigence, hunger, and nakedness of these children will constitute a grave and severe indictment of them before God, the Father of mercies, if they harden their hearts and do not contribute generously."

"But at this tragic moment of history, when—alas—material and spiritual ruins are piled high, * * * charitable enterprises, which, perhaps, seemed capable of dealing with normal needs of this kind, are certainly inadequate. For we almost seem to see with our own eyes the vast hosts of children weakened or at death's door through starvation. They hold out their little hands asking for bread 'and there is no one to break it unto them.' Without home, without clothing, they shiver in the winter cold and die. And there are no fathers or mothers to warm and clothe them. Ailing, or even in the last stages of tuberculosis, they are without the necessary medicines and medical care. We see them, too, passing before our sorrowful gaze, wandering through the noisy city streets, reduced to unemployment and moral corruption, or drifting as vagrants uncertainly about the cities, the towns, the countryside, while no one—alas—provides safe refuge for them against want, vice, and crime."

"* * * As all know, there would not be such a mass of delinquents in the common jails if greater and more suitable measures were taken to prevent especially juvenile delinquency. And if everywhere there grew up a healthy, honest, and industrious youth it would be easier to find citizens remarkable for their probity, fortitude, and other mental and physical qualities."

From Encyclical Letter of
Pope Pius XII,
January 6, 1946

MIGRANTS' CHILDREN NEED DAYTIME CARE

Good care can be given these children when public and private agencies work together

by *IONE L. CLINTON*
Industrial Division
U. S. Children's Bureau

● Children in migratory farm families need day-care services because as a rule everyone in the family who is old enough to take proper care of children goes to the fields when there is work to be had. For wages are low and the work is far from steady.

Occasionally a member of the family does stay home in the shelter with the young children. But it is likely to be an earnest 8-year-old. Even if a mother or aunt now and then stays home, it is just about impossible for her to give the children good care in the makeshift shelter that is "home" to the family at their various stopping places.

Instead of leaving the children at home it is more usual for the family to take them to the fields. Sometimes the babies and smallest children are locked in cars near the rows where the rest of the family are picking. Or a baby may lie on the ground at the end of the row, often without shade or other protection. The children start very early to help with the work. Sometimes even those as young as 6 or 7 work right along with the older members of the family.

Migratory families generally live and work in places that do not have child-care centers or foster-family homes for day care, or even schools. Even if they stop at a town in which there is a place where children can receive good care while the parents work, it is likely to be closed to migrant children. (For some of the obstacles that migratory children encounter in attending school, see *The Child*, November 1945.)

In a few places migratory farm families are able to get care for their children during the day because in the area where they happen to be working some agency is operating a nursery school or child-care center especially for the use of such families.

The quality of care that such a center or nursery school is able to give the children varies widely, according to the resources supporting it and the cooperation that the agency operating it receives from other agencies, from the growers, the parents, and the community, and especially according to the extent to which the plan for day care of children is based on a broader plan to better the living and working conditions of the families.

Pioneering by Home Missions Council

Such a broad plan has been followed by the Home Missions Council of North America, an interdenominational organization, which has long realized that the privations suffered by the children of migratory farm workers could be lessened if these children were cared for while their parents were at work. This organization for a number of years has been providing staff to operate child-care centers, enlisting the interest of the growers and the community, and contributing money to support the work. These services for children have been part of the council's plan for bettering conditions under which the migrant workers live and awakening the communities that benefit by the work of the migrants to their responsibilities to these workers.

This organization began establishing child-care centers for children of migrant agricultural workers about a quarter of a century ago, placing centers in four States in the East, in areas where large numbers of seasonal farm workers were employed. It has continued this work ever since, establishing centers in additional areas. By 1945 the council had established child-care centers in some localities in about half the States.

These centers have been established to meet varying needs and have been financed from whatever resources the council can manage. Before a center can be established the council's workers have to convince the growers and the children's parents of the need for such services. Usually whatever buildings and equipment can be had must be furnished by the growers. In some cases the program has been opposed by growers and by some other groups in the community. The council has always been hampered by lack of money and of help from public agencies, although in the past few years, in one State, it has been able to operate its centers with the help of Federal funds and

AFTER SCHOOL at a child-care center for migrant children. Most of their stopping places have neither centers nor schools that admit these children.

Photo for FSA by Rothstein

with the cooperation of State agencies.

Federal agency provides child care

About a decade ago the Federal Government began to provide child care for some migratory farm families. The Farm Security Administration, when it built camps in an effort to improve the living conditions of such families, also built nursery schools in some of the camps. Attendants trained in the care of small children were employed. Children were given good care, good food, and training in health habits. Through these schools the parents also were helped to learn about the care of children. The health of the children was watched closely by physicians and nurses. (For an account of this health work see *The Child*, October 1945.) But the funds for carrying on these nursery schools were cut off about 3 years ago when Congress gave the responsibility for operating these camps to another Federal agency and changed them into farm-labor supply centers, many of them for foreign workers without families.

In a few of the farm-labor supply centers that are still used for migratory families the nursery schools continue, although Federal funds are no longer available. In each of the six Texas centers, for example, the "center council," a community organization, recognizing how important nursery schools are for the center's children, uses money collected from the people living in the center to carry on these schools. Even with this support, continuation of these nursery schools is possible now only because the buildings and equipment that were provided through Federal funds remain in the centers and also because the same program's health services can still be had without cost to the families.

Lanham Act funds help

About the time when the funds for nursery schools in the Farm Security Administration farm-labor camps were cut off, some migratory farm families began to benefit through an effort by the Federal Government to provide care for the children of working mothers in industry with funds provided under the Community Facilities Act, also known as the Lanham Act. Some Lanham Act funds were used to provide child-care services in federally operated farm labor-supply centers in Florida, Virginia, and North Carolina.

Photo for FSA by Lee

HEALTH HABITS are part of everyday life at this nursery school for the children of migratory farm workers living in a farm-labor supply center.

Lanham Act funds were also given to help operate child-care centers in privately owned farm-labor camps in New York State, with gratifying results.

Public interest aroused

New York State is one of the States in which the Home Missions Council had for some years been operating child-care centers for migratory farm-workers' families. These centers had been operating in New York from 1931 to 1942 with the inadequate resources of the council and without the help of public agencies, which is so necessary to a successful program.

In the second war year the Nation's need for food, and the lack of labor to produce it, high-lighted the conditions under which the migratory families who worked on the crops were living. When the people of New York State began to realize what these conditions were many State and local public agencies, private organizations, and groups of citizens, as well as the general public, were aroused to improve them.

Out of this resolve to do something about bettering living and working conditions of the families grew a successful cooperative plan for daytime care of the children.

Public and private agencies cooperate

State agencies, such as the committee on child care and the farm-manpower service—both of the war council—and the department of health and the department of social welfare, began to work more closely with the Home Missions Council to improve the existing centers and to extend the care to more children. Thereupon Lanham Act funds were granted to help carry on the program. The money became available in time to help with the 1943 program.

The war council's committee on child care employed a worker to coordinate the efforts of all the groups active in the program. With the help of the farm-manpower service this employee worked with farmers to determine the need for centers and to arrange for the growers to furnish buildings for them. It was planned to set up centers in every camp where at least 15 children under 12 years of age were expected to be in the workers' families. Seven centers, caring for 167 children, were operated during the summer of 1943.

The State department of health inspected the centers to test the water supplies and make sure of other sanitary conditions. The children were given physical examinations and medical and nursing care by public-health physicians and nurses.

Community committees gave volunteer service to the centers and collected funds, and toys and other supplies for the children.

On the whole, the child-care program for the summer of 1943 was considered a success, although the services had many deficiencies and reached only a small fraction of the children needing care. (Additional detail on the work in 1943 is given by Mebane Hunt Martensen in "Care for Migrants' Children," Survey Midmonthly, May 1944.)

The following year the work of establishing child-care centers was continued until most of the major agricultural areas in which seasonal workers were employed had this service. Sixteen centers were operated; 357 children were cared for in them.

The care, however, was still far below the standards set by the State department of social welfare. Some of the centers were overcrowded. Some had no running water. Some staff members were not trained in taking care of children. But there was improvement over the previous year.

In 1945 the program continued to expand and improve. It included 18 centers, serving 439 children.

Money for providing or renovating quarters for the child-care centers was furnished by growers and canners. A few of the centers were located in separate buildings put up for the purpose in 1944. Others were in such places as a village recreation hall, the Sunday-school room of a church, a converted barn, and a hospital building.

Training conference held

Before the season opened the staffs of the centers were brought together for a training conference lasting a week. At this conference specialists discussed such subjects as infant care, nursery-school and play-school methods, first aid, recreation, and menu planning.

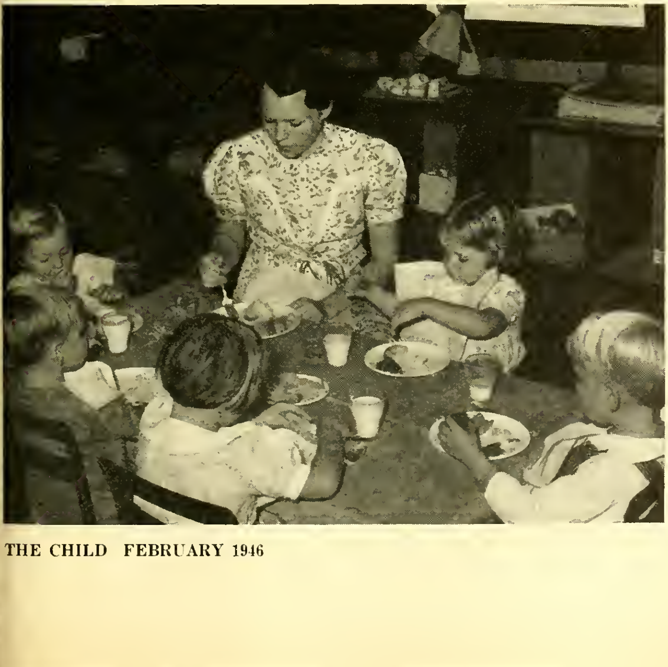
The hours of the centers were lengthened to match the working hours of the parents. In some places the centers were open 7 days a week; in some they operated from 6 in the morning till 9 in the evening.

Children up to 14 were encouraged to go to the centers; in one area a special play school for the older children in this group was set up for a short period during the summer. After school opened in the fall, school children came to the centers at lunch time and after school.

Since the camps were apart from the community it was impossible to use foster families for day care of children under 2 years of age. The centers therefore took care of them. Every effort was made to see that these very small children were taken care of in rooms separate from the other children, that only a few were taken care of by one person, and that they were cared for by the kind of person who would ordinarily take care of a baby at home or in a foster-family home.

LUNCH at the nursery school for children of migrant families. These children probably would get little to eat if they were in the fields with their parents.

Photo for FSA by Lee



Continued need recognized

Not only have the children of the migratory farm workers benefited from the care they have received in these centers, but the growers and canners employing them have shown that they considered the centers valuable by contributing to the cost of operating them. The success of the centers and the continued need for them was recognized by the Governor of New York in a recent message to the legislature, in which he recommended that State funds be provided to continue the centers in 1946, when Federal funds will no longer be available.

As long as seasonal agricultural labor is done by migratory family workers day care for their children will be needed. This need will increase as migratory farm families replace prisoners of war and nationals of other countries who have been brought into the United States to do agricultural work.

Two programs offer guides

Groups making plans to meet this need may well note what has been done in New York State, where success in a child-care program for migratory agricultural children has been achieved through cooperative action among many groups. The program of the Farm Security Administration also offers guides for planning child-care services in camps for migratory families. These two programs illustrate effective child-care services that have been developed as part of broader programs for bettering the living and working conditions of migratory families.

(This is the third in a series of articles on children of migratory agricultural workers.)

Reprints available on request

PAN AMERICANS HOLD FIRST SOCIAL-WORK CONGRESS

● Social service for the protection of childhood and adolescence was one of five subjects on the agenda of the First Pan American Congress of Social Service, held in Santiago, Chile, September 9–15, 1945, with delegations representing schools of social work and governmental agencies of a majority of the American Republics in attendance.

The congress was held to commemorate the twentieth anniversary of the founding of the first school of social work in Latin America, which was established in 1925 under the auspices of the Junta de Beneficencia, or Welfare Board, of Santiago. The director of the school, Mrs. Luz Tocornal de Romero, was unanimously elected chairman of the congress. Representatives of the six schools of social work now functioning in Chile participated in preparations for the congress, with the active cooperation of the associations of social workers, which include approximately 650 graduates of the various schools.

Social-service contributions

Since Chile has the longest tradition in the training of social workers, delegates from other American countries where schools of social work are of more recent establishment were particularly interested in seeing the Chilean graduates at work in various social agencies. Of particular interest to persons concerned with child welfare was a survey of the contributions made by social service to the principal child-welfare agencies of Chile, a report of which was presented by Julia Reveco, vice president of the General Association of Social Workers of the Government. This paper was prepared by a committee of nine representatives of public agencies concerned with the care of children from infancy through adolescence.

"With legitimate pride we can say that social work, or rather social workers, have come to constitute the principal element in the action developed in our country by agencies and institutions concerned with the various aspects of the welfare of children and adolescents," the report stated as it traced the long road traveled since the eighteenth century, when the first institution was established to receive babies abandoned anonymously in the traditional "torno," or revolving box. This remained in operation until 1927, when Dr. Luis Calvo Mackenna modernized the institution, employing members of the first graduation class of the first school of social work in Chile.

Broad vision and leadership

Reports presented by delegates from other countries gave eloquent testimony to the broad vision and leadership of representatives of public and private agencies concerned with the health and welfare of mothers and children in different sections of the American continent.

The congress was honored by the presence of the director of the American International Institute for the Protection of Childhood, Dr. Roberto Berro, and of the Institute's secretary, Dr. Victor Escardó y Anaya, who came from Montevideo with Dr. Julio Bauzá, director of the Consejo del Niño, the official children's agency of Uruguay. A meeting of the International Council of the Institute, was held in Santiago during the week of the congress.

Uruguay is the headquarters of this official Pan American child-welfare agency, in recognition of the progressive leadership of such prominent Uruguayans as the late Dr. Luis Morquio, the pediatrician who set such high standards for his own country that he was an example for others. It was therefore natural that a report on child welfare in Uruguay should be a feature of one of the plenary sessions. The report, presented by Augusta Schroeder, director of the School of Social Service of Uruguay, dealt extensively not only with the health services provided by the Consejo del Niño, but with the broad program of foster-home care which is a feature of the agency's program.

Staff training discussed

Dr. Alberto Zwanck, founder of the first school of social work in Argentina, discussed in philosophical vein the training of professional staff for children's agencies. A paper on social services for children and the training of child-welfare workers in the United States, prepared for the congress by Katharine F. Lenroot, Chief of the Children's Bureau, was presented at a plenary session by the chairman of the United States delegation.

Resolutions adopted recommended establishment of an international welfare organization under the auspices of the Economic and Social Council of the United Nations Organization; closer international and inter-American cooperation among schools of social work; organization of an inter-American committee of schools of social work; establishment of associations of social workers in the various American countries; support for the Division of Labor and Social Welfare Information of the Pan American Union and of the American International Institute for the Protection of Childhood. Others dealt with the necessity for developing strong and broadly conceived programs and agencies for child welfare in the various countries; industrial social service; social service in rural areas; social service in legal-aid bureaus; medical-social work; and similar topics.

The congress voted to hold the Second Pan American Congress of Social Service in Brazil in 1947 or 1948.

Elisabeth Shirley Enochs

IN THE NEWS

Meeting of National Conference on Labor Legislation

Labor commissioners and representatives of organized labor from 42 States met in conference in Washington December 3–6, at the call of Secretary of Labor Schwellenbach. The purpose of the meeting was to discuss common problems and formulate ideas to guide labor departments in carrying out their responsibilities and in giving leadership to improvements in labor laws through the coming year.

The recommendations on child labor and youth employment emphasized the importance of immediate action in planning legislation and developing public opinion as a basis for a successful legislative program in 1947, when many of the State legislatures meet. The committee's report on child labor and youth employment made special reference to the importance of legal protection for children employed in industrialized agriculture. It specifically included industrialized agriculture in its recommendation for the immediate establishment in State laws of a 16-year minimum age for employment during school hours and a 14-year minimum age for employment outside school hours and during vacation, the higher minimum to apply also to employment at any time in manufacturing, mechanical, and processing establishments.

This report also recommended amendment of the Federal Fair Labor Standards Act of 1938 to cover employment of children in industrialized agriculture and gave wholehearted approval to amendments pending in Congress which would strengthen the child-labor provisions of the act by providing a direct prohibition against the employment of children contrary to the child-labor standards of the act and by extending coverage to establishments engaged in interstate commerce regardless of whether or not they produce goods for shipment in interstate commerce.

The committee on migratory labor and housing, concerned with the plight of displaced persons, made the following recommendations, which are particularly significant for children:

1. Responsibility of the State Labor Departments and of the United States Department of Labor

The State labor departments and the United States Department of Labor should assume and continue active supervision of the interests of migrant workers, since they are an integral part of the total labor force. With the cooperation of the States, the United States Department of Labor should serve as a clearing house for information on working and living conditions of migrants and their protection under labor legislation.

2. Application of Labor Laws to Migrants

All workers who work for hire should have equal protection and security under all State and Federal labor and social-security laws. Child-labor laws and school-attendance laws should be made applicable to all children employed in agriculture, except that child-labor laws should not necessarily apply to children working for their parents on home farms. Special services may be necessary for migrant children in order that they may have full educational opportunities. State labor departments should be authorized by law to license labor camps and to establish and enforce standards for their construction, health and sanitary facilities, and maintenance.

3. Recruitment and Regulations of Labor Contractors

Legislation should be enacted on a Federal level to regulate the activities of labor contractors who operate across State lines, and wherever necessary, similar legislation should be enacted by States to set up State controls.

4. Transportation

Authority should be vested in the Interstate Commerce Commission to regulate vehicles which carry laborers across State lines and to ensure standards of safety and comfort. Similar supervision of transportation should be assured under appropriate State authority, and a plan of Federal-State cooperation should be developed in the interest of safe transportation of workers.

5. Health of Migrant Workers

A high standard of health for migrant workers prevents the spread of communicable disease, protects the health of the workers and of the regular members of the community in which they temporarily live, increases the productivity and efficiency of the workers, and sustains their morale.

States should develop plans and provide funds for medical care. In such planning, local facilities should be utilized and community participation secured. Federal assistance should be secured when the needs of migrants cannot be met by local facilities without impairing services needed by the regular residents.

6. Importation of Foreign Labor

This committee recommends that importation of foreign labor and the use of prisoners of war be terminated. No further importation of labor should be undertaken by the Federal Government except after consultation with the State labor department of any State involved regarding labor needs and supply and the conditions under which such workers will be employed.

7. Implementing and Continuing Migrant-Labor Programs

This committee recommends the appointment of State committees under the leadership of the State labor departments, to consist of members of the public, organized labor, legislators, and membership of State departments of government having direct interest or responsibility in the problem. The duty of such a committee should be to study the migrant-labor problems of the State, with a view to recommending and promoting legislation to meet existing or changing conditions in the migrant-labor field.

The committee further recommends the organization of a Federal interdepartmental committee on migrant labor, under the sponsorship of the United States Department of Labor, composed of Federal agencies having responsibilities toward migrant workers. This committee should study and report upon the working and living conditions of migrants. It should pool the resources of the various agencies in order to devise and carry out a program to ensure for migrants standards equal to those available to workers in all other occupations.

General Advisory Committee on Protection of Young Workers Meets

The Children's Bureau General Advisory Committee on Protection of Young Workers met December 13 and 14 to advise with the Bureau on its child-labor and youth-employment program.

As an aid to groups seeking post-war advances in child-labor standards and laws, the reappointment of a subcommittee on children in agriculture was recommended, which among other things would develop a definition of agriculture suitable for use in child-labor laws. Committee members wished children working in industrialized agriculture to have the same kind of protection as is now generally given by child-labor laws to children hired for work in other industries.

The committee also recommended that the Bureau extend its research in the field of employment and welfare of young workers so that information on what is happening to young workers will be available for planning. It also suggested that the Bureau, in appropriate ways, emphasize the importance of good placement services for young workers, and of studying needs for and methods of providing student aid to enable young people to continue in school.

States Continue Planning for Children and Youth

Georgia

The youth division of the Georgia Citizens Council is planning to hold a series of six youth forums in various sections of the State.

Illinois

The Child Welfare Commission of Illinois, Senator Charles W. Baker, chairman, recently issued in pamphlet form its report to the 1945 general assembly describing the child-welfare functions of State agencies in the fields of health and medical care, education of handicapped children, and public-welfare services for children. The commission's new address is 176 West Adams St., Chicago 3, Ill.

Kansas

Dr. John B. Geisel, Southard School, Topeka, has recently been elected president of the Kansas Council for Children.

Maryland

J. Milton Patterson, State director of public welfare, has succeeded Joseph Rogan as chairman of the Maryland Youth Service Commission.

New York

The New York State Youth Commission has recently issued Bulletin 1, "Stop Pushin'," explaining the work of the State youth commission, for the guidance of localities wishing to share the financial and other assistance available under the youth-commission program.

Tennessee

The Children's Commission on Legislation, Senator Homer Weimar, Cotton States Building, Nashville, chairman, has announced its decision to proceed as a study group. Three subcommittees have been named to consider improvements in legislation relating to guardianship, juvenile courts, and child labor.

Wisconsin

A joint interim committee on juvenile delinquency has been established by the 1945 Wisconsin Legislature, with Senator Rudolph M. Schlabach of LaCrosse serving as chairman. Hearings are being held in various parts of the State.

Child Labor in Tomato-Packing Shed

That 9 of the 25 employees of a tomato-packing firm were children employed in violation of standards established under the child-labor provisions of the Fair Labor Standards Act of 1938 was disclosed recently by an investigation made by a representative of the Children's Bureau. Six of these youngsters were under 14 years of age, and three 14- and 15-year-olds were employed after 10 p. m.

It was found that one of the partners in the firm had hired the children, asked them their ages, and requested them to obtain "releases" from their parents. In a written statement an 11-year-old child reports, "Mrs. ______ hired me. She asked my age. I told her I was 11. She told me to get a minor's release from my father or mother. My father said it was O. K., to get my mother to fill it out. I haven't done it yet. I am about 5 feet and I weigh about 86 pounds."

Because it was the first inspection of this packing shed and the employer apparently had not been specifically advised with respect to the child-labor provisions of the act, the violations were not regarded as warranting criminal action. Civil action, however, was deemed advisable because of the flagrant nature of the violations. In a Federal district court a consent decree was obtained enjoining the concern from employing minors contrary to the Federal act in the future.

Maryland Pays Unemployment Compensation to Discharged Young Workers Who Return to School

Recent action of the Maryland Unemployment Compensation Board in liberalizing the interpretation of that State's unemployment-compensation laws puts Maryland in the forefront of the States in treatment of unemployed young workers.

Although the board had never ruled officially that young unemployed workers would be ineligible to receive unemployment compensation if they returned to school, it was generally understood that attendance at school would make an unemployed worker "unavailable" for reemployment and therefore ineligible to receive benefits.

A recent official ruling of the board states that unemployment benefits may be paid to young people who have earned them, whether or not they are in school, providing that they have work permits and stand ready to accept a job when one is offered. Moreover, a special procedure has been worked out with the Baltimore schools to identify to the unemployment-compensation board young workers who have returned to school. The teacher certifies on school stationery that the discharged worker is a pupil. The young worker presents this to the board and collects his unemployment-compensation check, at a time that does not interfere with school.

According to a report from Russell Davis, chairman of the unemployment-compensation board, about 390 young women and 530 young men filed claims with the board between August 17 and October 5, 1945. Of these, 90 girls and 210 boys were found to be ineligible because of insufficient earnings. The remaining 620 applicants of school age were eligible to receive benefits. It is estimated that the entire cost to the State will not exceed $150,000. Early in January Maryland reported that benefits had been paid to between 200 and 300 young people under this arrangement.

FOR YOUR BOOKSHELF

HELPING TEACHERS UNDERSTAND CHILDREN, by the staff of the division on child development and teacher personnel, American Council on Education, Washington, D. C., 1945. 468 pp. $3.50.

In essence, this significant book, which was prepared for the Commission on Teacher Education, is the history of the growth and maturity of a group of teachers in a school system somewhere in this country. It describes the cooperative method by which a training program in the growth of personality in children was established in a school system. The writing is generally well done, for the reader catches the drama that is inherent in the process through which one person, the teacher, grows by helping the pupil in his own growth. The experiences gathered in this "in-service training" of the teacher are humbly and intelligently evaluated. The volume will be most valuable for leaders in school planning, workers in the field of teacher education, members of school boards, and teachers. Since the experience of learning from children is a universal one, however, the volume should be of interest to anyone concerned with the growth of children and giving services to them.

K. A. Z.

COMMUNITY ORGANIZATION FOR SOCIAL WELFARE, by Wayne McMillen. University of Chicago Press, Chicago. 1945. 658 pp. $4.75.

Professor McMillen has written this comprehensive study primarily as a textbook for beginners, and in his introduction he compares some of his apparently obvious instructions with the directions given in a certain cookbook for brides, "Into a *clean* bowl, break a *fresh* egg . . ." Nevertheless, this book should be useful not only as a textbook for courses in community organization, but to a large group of practicing social workers and to other persons interested in improving social-welfare provisions in their communities.

The author divides the book into two parts: Part 1, Process, and Part 2, Structure. Part 1 discusses community organization as a process in social work with particular reference to the function of the social worker. The roles of private and public agencies in providing channels through which this process may be promoted are explored in view of the changing relationships between these two types of agencies and the general recognition that the great bulk of social services must be administered by public authorities.

This section takes up various methods of developing agency leadership, lay and professional. Methods of determining community needs, of developing a plan of action, and of following through on this plan and using the facts obtained are described and evaluated. Stressing the importance of the initial approach to the community, the author offers specific suggestions to the social worker who is entering upon his responsibilities.

Part 2 discusses the functions of the principal private and public agencies, National, State, and local, engaged in furthering the community organization process. The author speculates on some of the developments that may lie ahead.

Professor McMillen says that "there is a possibility that planning and coordination in the social-welfare field may ultimately become an official function of government." He also says "It is not unlikely that the future of community organization activity in rural areas rests in the hands of the local departments of public welfare," and "the alertness of the local public agency to its opportunities in this area will in turn be determined in large measure by the quality and continuity of the influence of the State authority." He gives special consideration to the qualifications needed for the traveling field agent. One wishes that there might have been discussion of the division of responsibility between the general field staff and the specialized field staff, such as child-welfare consultants, in the community-organization process, particularly in relation to local communities.

A number of agency reports and professional papers, many of them not elsewhere in print, are reproduced in whole or in part; these make the book especially useful for classroom teaching or in-service training.

M. A. E.

RECENT C. B. PUBLICATION

HEALTH AND WELFARE SERVICES FOR MOTHERS AND CHILDREN IN THE UNION OF THE SOVIET SOCIALIST REPUBLICS, from original Russian sources, by Anna Kalet Smith. Processed. U. S. Department of Labor, Children's Bureau, Washington. 1945. 40 pp.

Against the background of legislative and administrative machinery of the U. S. S. R., this report, compiled from published sources, without any attempt at evaluation of the material, describes in detail the organization and work of the agencies engaged in services for mothers and children. A limited number of copies is available for distribution.

CHILDREN AROUND THE WORLD

GUATEMALA

Child-Welfare Society (Sociedad Protectora del Niño)

The Child-Welfare Society of Guatemala, which is the most important private agency of its kind in that country, has recently celebrated its twenty-fifth anniversary and has published a history of its activities.

Organized in Guatemala City in 1920 for the purpose of improving the situation of children in low-income families, the society began by setting up, with limited private contributions, the first day nursery in Guatemala for children of employed mothers. Subsequently two other such nurseries were added. The establishment of the first nursery was followed by the organization of a series of talks to groups of mothers on child care and personal hygiene. These talks, which are now a regular part of the society's program, are given by physicians, dentists, and others, all of whom donate their services.

The Government of Guatemala soon realized the value of the society's work and began to add its subsidies to the private contributions which theretofore had been the society's only source of income.

Medical services

In the course of time the society was able to establish a prenatal clinic with facilities for laboratory tests and treatment for venereal diseases. The women patients of the clinic are attended at childbirth in their homes by midwives paid by the society. A kindergarten, a well-baby clinic, an eye clinic, a small hospital for children, and three dispensaries were gradually added to the society's resources. At the dispensaries medical examinations are given to children at the time of their admission to a day nursery and every 3 months thereafter. The examination includes a tuberculin test. The results of the examination are noted in detail on the child's individual record. Immunization against infectious diseases is also provided. The Dental Association of Guatemala has equipped a dental clinic for the women and children aided by the society.

The society has established a school to train girls for service as nursemaids in private homes, in an effort to do away with the employment of untrained young girls for that purpose.

Children helped to get education

The society also helps financially those children who formerly had attended its kindergarten and who upon reaching the age of compulsory school attendance are unable to attend school without outside help.

A children's library is maintained; a popularly written book on child care has been published, and a monthly magazine, *El Niño*, is issued.

The society serves an average of 1,000 children daily.

Close cooperation is given to the society by Government agencies, particularly the Bureau of Public Health, which donates vaccines and other material and allows the use of its laboratories.

SOURCE: *25 Años de Labor, Sociedad Protectora del Niño, Guatemala, 1945, 122 pp.*

BRAZIL

Introduction of Social Insurance

The principles of a general social-insurance system for Brazil, of much broader application than the one now in existence in that country, were formulated in a decree-law of May 7, 1945. According to this law social insurance is to be compulsory for every gainfully employed person more than 14 years of age, whereas at present it is required for workers in some occupations only. The decree does not apply to Government employees, for whom a separate system of insurance is provided. The aim of the new decree is to assure to all Brazilians, and to foreigners legally residing in the country, the necessary means in case of temporary or permanent incapacity, or of old age, or of death of the family breadwinner.

The benefits under social insurance will include not only money, but also health and welfare services. The cash benefits will amount to a specified percentage of the minimum wages prevalent in the locality. The health and welfare services will consist of medical and hospital care, including preventive care, and measures for the improvement of the food, clothing, and housing of the insured persons and their families. Special attention is to be given to welfare services for mothers and children.

For the purpose of meeting the cost of the social insurance, the workers, the employers, and the Federal, State, and local governments will be required to make specified contributions.

Federal-State cooperation

Social insurance and the related services will be administered by the Social Welfare Institute, a Federal agency, which will cooperate with the States, municipalities, other public agencies, and private organizations.

The preliminary work for the setting up of the social-insurance system is entrusted to an organizing committee, to be appointed by the President of the Republic; the committee is to report to the President within 6 months. An appropriation is provided to meet the committee's expenses.

Fines are prescribed for violations of the present decree-law or of the subsequent executive orders for its administration.

SOURCES: *Revista do Trabalho, May 1945; and Diario Oficial, May 11, 1945 (both of Rio de Janeiro).*

Anna Kalet Smith

U. S. GOVERNMENT PRINTING OFFICE: 1946

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The CHILD

CHILDREN'S BUREAU • U. S. DEPARTMENT OF LABOR

- FUTURE OF CHILDREN AND YOUTH
- CHILDREN ACQUIRE NEW PARENTS
- AMERICAN ACADEMY OF PEDIATRICS STUDY

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The picture on the cover, of after-school activities at a school center, is a Library of Congress photograph (Collins for OWI).

U. S. DEPARTMENT OF LABOR
L. B. Schwellenbach, *Secretary*

CHILDREN'S BUREAU
Katharine F. Lenroot, *Chief*

CHILDREN ARE THE FUTURE

If ever the world needed to look to its children, now is the time. And we are now free to turn our attention to the best that we can do for the youth of our Nation and of the world.

Here in the United States we know that our programs for children are spotty and scattered. Health services are unavailable for children in many counties and small towns. The areas in which child-welfare services are provided are even more limited. Many States, and large areas within States, have school facilities that are inadequate in quantity, quality, and accessibility. Many of our child-labor laws still permit children to leave school for work at 14 or 15 years of age, and most of them fail to regulate the employment of children in industrialized agriculture. These are a few of our deficiencies.

"Our Concern Every Child" was the 1940 White House Conference challenge to make our programs for children Nation-wide. The war has delayed us, but we have 4 more years to go to make good on our 1940 convictions, before it is time for another decennial White House Conference on Children.

In "Building the Future for Children and Youth," the National Commission on Children in Wartime repeated the challenge and called for recognition of the principle that health and welfare of children, no less than their education, are public responsibilities. The commission urged the extension of these services, of educational opportunity, and of related programs necessary to full opportunity for children.

At the recent meeting of the commission the most active discussion centered on how we can bring home to the fathers and mothers in each city, town, and county the fact that these programs are their programs and that the health and welfare of their own children can be assured only if all children have access to these services as a matter of right. Can we doubt that if all parents realized fully what communities must provide if all children are to have their fair chance, we would get the legislation, the public appropriations, and the voluntary programs that we need?

In some 20 States we have State commissions on children and youth, or committees studying special programs needed for children. Their work will mean that in those States there will be a review of children's needs and there will be proposals for citizens' groups and State legislatures to consider and act upon. Let us extend such committees to the other States and carry the impetus to our home communities. Each community should determine to raise the average in its provision for children and youth until we can claim a well-rounded Nation-wide program.

From other countries are coming inquiries as to what the United States is doing and is planning to do for its youth. It is now time that we make definite commitment to provide whatever is necessary in public services and voluntary effort to equip our youth for a worthy part in the life of the world. To fail in this would be to betray not only our own Nation, but all who are trying to build the foundations of a just and enduring peace.

Leonard W. Mayo,
Chairman, National Commission on Children in Wartime
President, Child Welfare League of America.

Publication of The Child, Monthly Bulletin, with Social Statistics supplements from time to time, was authorized by the Bureau of the Budget, May 12, 1936, under Rule 42 of the Joint Committee on Printing, to meet the needs of agencies working with or for children for a regular channel of information on current developments, activities, policies, and programs for maintaining the health of mothers and children, providing child-welfare services, and safeguarding the employment of youth. Address The Child, Children's Bureau, U. S. Department of Labor, Washington 25, D. C. The Children's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. The Child is for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at $1 a year; foreign postage, 25 cents additional; single copies, 10 cents.

PUT CHILDREN FIRST

Communities have responsibility to see that every child has a fair chance in life

by *L. B. SCHWELLENBACH*
Secretary of Labor

• I take special pleasure in welcoming you, the members of this National Commission, to the Department of Labor. For 4 years you have been performing an invaluable public service as advisers to the Children's Bureau, to which our citizens have given not only the enormous responsibility of administering child-welfare, child-health, and child-labor laws, designed for the protection and enrichment of child life, but the broad mandate to "investigate and report upon all matters pertaining to the welfare of children and child life." I know from the testimony of Miss Katharine F. Lenroot, Chief of the Children's Bureau, and also from my own observations that the Bureau has been able to do a vastly better job because of the stimulus and counsel you have brought to it.

Future obligations to children

You came into being in 1942 as a National Commission on Children *in Wartime.* You meet now, in this first year of peace, to consider what your obligations to children are in the future. This war we have won is only the prelude to a far greater task—the task of reshaping the culture of our age. No longer can we live under the intolerable tyranny of recurring cycles of "prosperity" that collapse inevitably in human suffering and want, of "peace" that ends inevitably in organized slaughter of people. These tragic cycles are not inescapable afflictions of life; they are evidence of the failure of human ingenuity, the lack of generosity of spirit. We can, if we set our minds and hearts to it, banish those afflictions as certainly as we have banished smallpox as a killer of millions. But for this task we must have the closest collaboration of citizens and governments. We must have the kind of two-way channels of communication which you have created here. It is not enough for citizens to instruct their representatives to pass laws to enhance the common good—essential though that is in democratic government. Laws require responsible administration. Responsible and responsive administration requires continuing contact between citizens in government and citizens outside of government. You have an instrument for such contact in this National Commission. Maybe it needs redesigning to increase its effectiveness. That is for you to decide.

Responsibility of the community

As a citizen, I have always been deeply concerned with the responsibility of the community for seeing that all children have a fair chance, an even start in life. As a senator, I had the opportunity to lend my support to Federal aid for State and community services for children. As a Federal judge, I made it my practice never to rule on the case of any juvenile offender against the law without first acquainting myself with the circumstances of his family life that might have contributed to his difficulty. As all of you know so well, behind every youngster who tangles with the law you can usually find some failure of family or community to meet the needs of that boy or girl. To punish him or her for that failure would be not only a miscarriage of justice but an aggravation of the sickness that he or she suffers.

About 7 months ago I became your Secretary of Labor. It was not until then that I had the opportunity for fairly close observation of the work of the Children's Bureau. I confess when I took over the responsibilities of this office I had a certain skepticism as to the suitability of having the Children's Bureau in the Department of Labor. I have none today.

Congress has given the Department of Labor the duty to "foster, promote, and develop the welfare of the wage earners of the United States." Of course their welfare is inextricably bound up with the welfare of their children. That is as it should be. Indeed, I should like to add parenthetically, I am convinced we would get ahead with our business of putting our national affairs in order much faster if all of us were to measure our programs first in terms of their effect on the welfare of children and second in terms of our special interest.

In time there may develop a stronger governmental contender for this Bureau than the Department of Labor. For the present at least, I know of no locale from which the Children's Bureau could work which has a stronger claim to it than we have. My personal hope is that nothing will be done to disturb our close relationship

CHILDREN OF ALL AGES work in hopyards, long hours in the hot sun. Such children as a rule are not protected by any child-labor law.
Photograph by Lange for FSA

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with the Bureau unless and until it is given a larger and more substantial basis from which to operate.

One of the strengths of the Children's Bureau has been its recognition, almost from its inception, of the value of advisory committees. I doubt that there is another agency of Government which has made greater effort to develop teamwork among itself, the professions and agencies working in the same field, and the citizens of the Nation. This teamwork should go on.

Challenges conscience of America

One of the most fruitful results of this teamwork was the report which your own National Commission prepared and released on the eve of VJ-day. This report, published by the Bureau under the title, "Building the Future for Children and Youth," is a distinguished public document. You have challenged the conscience of America in your recital of the ways we are short-changing our children; of the mothers and babies who needlessly die each year; of the hundreds of thousands of children suffering from diseases and defects for which we make no adequate medical provision; the quarter-million youngsters who are brought into juvenile courts each year, many of whose troubles could and should have been diagnosed and cared for years before. You have called attention to great numbers of children of working mothers who may now be denied day care with the withdrawal of Federal funds. Children employed as messengers, as farm workers, and in other occupations unprotected either by Federal or State law, stare us in the face from the pages of your report. You have reminded us once more of the gross inequities in educational opportunity that we deal out to many children.

These startling evidences of our unfinished business for the children of the richest nation of the world should give pause to all of us. Some of them can be wiped out by building up the purchasing power of family incomes. Some of them can be remedied only by a determination of the American people that a larger part of their national income shall be spent in building up child-health, child-welfare, and educational services. Still others will be resolved only when we extend the protective arm of the law around all children in danger of exploitation, whether it be in industry, agriculture, or commerce.

Definite proposals

You know—I do not have to tell you—that the President is deeply conscious of the conditions which your report has summarized. His whole effort to lift minimum wages from 40 cents to 65 cents, to extend the child-labor provisions of the Fair Labor Standards Act, to lay the foundations of full employment and full production, will all help families provide more adequately for their children. The President's message to Congress on national health makes clear his conviction that provision of medical care and health services for children is as much a public responsibility as the provision of educational opportunities. He has called for more Federal support of education where that is needed and desirable. In all the major areas of your concern for children, the President has made definite proposals for action to the Congress.

Everything that you, as individuals, can do to increase the understanding of the American people of such legislation should be done—now. You, better than most, are able to make our citizens aware of the urgency for action.

A few minutes ago I remarked that the war we have won is only the prelude to a far greater task. I called it the task of reshaping the culture of our age. Perhaps I put it in too fancy terms. What I mean is something quite simple. I had occasion recently, in talking to the Detroit chapter of the Lawyers Guild, to recall some remarks made to me by a man who had lived through the tragedies of our last great depression and had been in a position to help piece together the spirits of men broken by that economic collapse. Men who had been business titans just a few years before came to this official for a clean shirt, for railroad fare back home, for a menial clerical job—for anything that would give them just a little sense of decency, a little sense of security in life. "One night," my friend said to me, "after battling against that kind of flood for 12 consecutive hours, a light dawned for me. Every man who came to my desk, rich man and poor man, insisted that the only thing he asked from this world was security for himself and for his family. Suddenly it dawned on me. There was only one place where security could be found. It was in the security of your fellow man. If he was secure, you stood a good chance of being secure."

Security and the good life for all

If the light that flashed through to this friend of mine could illumine all of us I believe it would reshape the culture of our age in a grand way. If we could see intuitively that the way ahead for each of us is to put all of us first, we might remake this age. One way in which we might begin would be to give greater heed to the very problems that your commission has been coping with: The needs of children, all children, of whatever race, creed, or family circumstance. If we could see that the lack of physical stamina and psychological security in other children threatens the physical stamina and psychological security of our own children, we might, for the best of selfish reasons, quicken our pace toward achieving security and the good life for all.

You members of this National Commission are well launched in such an endeavor. You have my profound admiration and respect. What you accomplish in your sessions here this week will, I am confident, help all of us to focus our attention, our imagination, and our energies on this larger objective.

Remarks made at meeting of the National Commission on Children in Wartime, at the Children's Bureau, Washington, February 5, 1946.

PROGRESS IN BUILDING THE FUTURE FOR OUR CHILDREN AND YOUTH

National Commission on Children in Wartime passes torch to a new peacetime commission

by *EDITH ROCKWOOD, Office of the Chief, U. S. Children's Bureau*
Secretary, National Commission on Children in Wartime

• The National Commission on Children in Wartime held its final meeting February 5 to 7 at the Children's Bureau and recommended for peacetime the appointment of a National Commission for Children and Youth. A plan for setting up the new commission was outlined.

Presided over by its chairman, Leonard W. Mayo, president of the Child Welfare League of America, the commission met to inquire into what progress had been made in carrying out the proposals made in its 1945 report, "Building the Future for Children and Youth."

Dr. Mayo reviewed the commission's work since it was first called together in March 1942 by the Children's Bureau. He described the work as "pooling all available data about children, promoting what we hope have been practical ideas for the solution of some of the problems, and prodding at every effective point to the end that something shall be done about it."

Speaking of the outlook for children in the reconversion period, Boris Shishkin, American Federation of Labor, said that in the past 4 years millions of families have left their homes to live in other places, that this shift is still going on, brought about by economic necessity, and that the effect on the family has been profound. Another basic fact, he said, is that even at the wartime peak of employment in 1944, 37 percent of the families of wage earners were receiving an income substantially below the requirements for health and decency.

Three major changes in the family have taken place in the last 30 or 40 years, said Mrs. Sidonie M. Gruenberg, director of the Child Study Association of America; namely, a reduction in size, an increase in mobility, and the employment of women in business and industry.

Dr. Paul B. Cornely of Howard University told of a survey of maternal and child-health services in a number of cities, which showed serious gaps in health and welfare activities for both white and Negro members of the community, but especially for Negroes. Progress has taken place so far as clinic and health facilities for the Negro child is concerned, but there still remains a problem, particularly in the rural areas of the South.

Maternal and child health

Dr. Henry F. Helmholz of the Mayo Clinic reemphasized the commission's objective to extend health services and medical care until they reach all the mothers and children in the country. He discussed reactions to the commission's proposal for expansion of maternal and child-health services and services for crippled children, including bills introduced in Congress and recommendations made by the American Academy of Pediatrics for changes in these bills. Dr. Helmholz described briefly the study of child-health services now being made by the Academy, with the cooperation of the U. S. Public Health Service and the Children's Bureau.

Ruth Houlton, New York City, reported that nurses in the National Organization for Public Health Nursing know of the great gaps in maternal and child-health services. A study has shown, said Miss Houlton, that the mortality among mothers and infants is greater in places where there are no public-health-nursing facilities.

Mrs. Faye Stephenson, Cleveland, told of the difficulties encountered by a workingman in getting care for his 3-year-old child, who was suffering from a ruptured appendix and pneumonia, and added that it took all the family had saved in 2 years to pay for the medical care needed.

Senator Claude Pepper of Florida spoke of the approximately 40 percent of the men eligible for selective service who were incapable of fighting because of physical or mental defects, many of which could have been corrected in youth.

The responsibility for these men's unfitness, he said, belonged largely to the communities where they grew up, to their States, and to the Federal Government. The selective-service figures, Senator Pepper said, have made the Nation more conscious than ever of the need for making the boys and girls of this country healthy and strong.

Child-welfare services

Mrs. Kate Bullock Helms, chairman of the Bureau's General Advisory Committee on Social Services for Children, spoke of the need for expansion of child-welfare services, as recommended by the commission. Mrs. Helms illustrated this need from her experience in South Carolina, where she is director of the Division of Child Welfare of the State Department of Public Welfare. Child-welfare service is a thread that goes through all the programs for children, Mrs. Helms said. It is the child-welfare worker who may bring a child to a clinic; who finds a child not in school and finds what he needs in order to go to school; who refers the child needing employment to the proper place; who may be able to help a child wrongly placed; who is called upon to work with a child who shows behavior problems.

The most important thing we need, Mrs. Helms went on to say, is additional funds under the social-security program to allow an expansion of child-welfare services. Child-welfare services should be on a State-wide basis and should be available to every child who needs services, whether in a city or in a rural community "away back in Hello Swamp." Also there should be improvement in the skill of workers. The lack of child-welfare staff is indicated by the fact that in five out of six counties in the United States we do not have the services of a full-time child-welfare worker. With 225,000 children in foster care in family homes and institutions, we need funds for foster care and workers to aid in strengthening and improving such care. We need funds and places for temporary care for children who are delinquent and dependent, and workers to arrange for such care. We know, Mrs. Helms continued, that Federal funds are needed for a broad program of day-care services for children, including group care that cannot be provided through the school program. In our State, she said, it has been through this program that we have been able to get better services for minority groups, including the Negro children and many white children in remote areas.

Security for family support

In relation to the commission's recommendations for extension and improvement of social-security programs, Jane M. Hoey, Director, Bureau of Public Assistance, Social Security Board, described the Board's recommendations.

With special reference to how children will be benefited, Miss Hoey explained extension of old-age and survivors insurance to all persons employed, including the self-employed, and raising the initial old-age benefit to low-income groups. Similar extension for unemployment compensation is proposed, and minimum benefit standards. Disability insurance and dependents' benefits under unemployment compensation are important for children and would reduce the number of persons who would have to apply for public assistance.

Other improvements, according to Miss Hoey, would be: Extension of public assistance to all people who are in need, not merely to special groups; special grants to meet the need of low-income States; medical care for those on assistance rolls; and, in the program for aid to dependent children, elimination of stated maximums so that the Federal Government will bear half the cost.

Federal aid for education

Speaking of the Commission's proposal that Federal support be given to education, Dr. Willard E. Givens, National Education Association, said that if the United States assumes leadership in world affairs, we must invest at least twice as much in our schools and colleges as we have been spending. Our elementary and secondary schools have been using 2½ billion dollars a year. If we expand them as a democracy should, and take into account extending the schools downward into the kindergarten, and also upward, we would need 5 billion a year.

Dr. Givens reported that teachers' salaries in terms of living costs are smaller than before the war. One teacher in every ten, he said, is now substandard in training, because it is impossible to get enough people who are qualified to teach. He explained proposals for Federal aid for education now before Congress and added that the proposed grants will give the most help to the minority group of the South that needs it most.

Floyd W. Reeves, University of Chicago, said that half of the most promising youth of our country drop out of school before they should, because they cannot afford to remain in school. We must make it possible for our youth to take advantage of educational facilities, he said.

Child labor and youth employment

Katharine F. Lenroot, Chief of the Children's Bureau, told the commission that wartime child-labor problems are continuing, although they are somewhat reduced from the wartime peak. Violations of child-labor laws continue in serious numbers, she added.

Miss Lenroot, as chairman of the Federal Interagency Committee on Youth Employment, reported that this committee and the Bureau's General Advisory Committee on the Protection of Young Workers have been studying the problems that confront young workers in the reconversion period, including the need for good counseling and placement service, the extent to which young people face unemployment, and the difficulty of returning to school after being employed.

The committees recommended, Miss Lenroot said, that leaflets be prepared, one for community groups to aid them in finding out what is happening to young workers, another for young workers themselves to give them information on their legal rights and responsibilities.

In connection with the commission's recommendations for strengthening Federal and State child-labor laws, Miss Lenroot stated that the Senate Committee on Education and Labor had recommended amendments to the child-labor provisions of the Fair Labor Standards Act of 1938 which would materially strengthen and extend the child-labor coverage of the act.

The proposed amendments include employment in commerce as well as in establishments shipping goods in interstate commerce, and directly prohibit employment of children contrary to the act.

Miss Lenroot also reported the progress that was made in 1945 and 1946 by State legislatures (Maine, Illinois, and Georgia) in raising the minimum age for employment.

Efforts to attain 16-year minimum-age legislation in 1946–47 have been recommended also by the Council of State Governments.

Progress reports were also made on the commission's proposals relating to adoption, guardianship, leisure-time services, and the coordination of mental-hygiene programs for children.

Planning for children and youth

How State and local planning for children and youth, as recommended by the commission, is carried on in Michigan was illustrated by Walter M. Berry, executive secretary of the Michigan Youth Guidance Commission. This commission, composed of State officials, and its advisory council representing State-wide organizations, can point to many legislative achievements in 1945. These include legislative authority to continue the work and an appropriation to support it. The advisory council's four committees have to do with (1) community resources for education, recreation, and character building, (2) children with special needs, (3) safeguarding youth through law enforcement, and (4) programs for children with behavior problems. Seventy-four counties in Michigan, said Mr. Berry, have county youth-guidance committees.

Mrs. Kate Bullock Helms explained the plan of organization and work of the South Carolina Youth Conservation Committee recently appointed by the Governor. A list of such commissions in other States was distributed.

Mrs. Robert M. Jones of Seattle asked why lay people in communities are not more conscious that there is a need for them to be active in these programs. It was agreed that real accomplishment for children rests on community groups taking hold of their own situation; also that national groups need to supply informational material that will help people at the grass roots to see their opportunity and their obligation to seek action needed. Kermit Eby, Congress of Industrial Organizations, said the majority of workers do not realize what is possible through education. They do not realize what can be accomplished in the field of health. We have to keep a commission like this going, he said, if for no other reason than to explain to American families that the schools belong to them.

Children in war-devastated areas

The suffering and the needs of children in some war-devastated areas were described to the commission by Dr. Leona Baumgartner, who was in France for the American Red Cross last fall; John Dula of UNRRA, recently back from Greece; Mrs. Kuei-Luan Tien Niu, of the National Association for Refugee Children in China; Dr. John W. Useem, formerly of the United States Navy; Dr. A. B. M. Sison, of the Philippine Islands.

Three of the resolutions adopted by the commission are:

Resolution on food

The National Commission on Children in Wartime, impressed with the reports of the starvation and destitution from which the children of war-devastated countries are suffering, fully cognizant of the fact that immediate and effective relief is essential to the survival of civilization, and confident that the people of the United States will fully support all necessary measures to extend such relief for as long a period as they may be required, resolves:

1. To extend to the President of the United States its enthusiastic commendation of his order of February 6 on the world food crisis, designed to put into effect in the shortest possible time a number of emergency measures to help meet critically urgent needs, such measures to include former enemies as well as the liberated peoples and those who have fought beside us;

2. To commend the inclusion in this program, in addition to wheat, of fats and oils, and meat, and especially to commend the inclusion of dairy products so essential to preserve child health;

3. To pledge to the President of the United States the utmost effort of the members of the commission working individually and through their respective organizations, to enlist the cooperation of every man, woman, and child in this program, as requested by the President, believing that the people would accept rationing should that be necessary to assure adequate relief abroad and equitable distribution at home;

4. To urge the Congress of the United States to take immediate steps to appropriate the remaining $600,000,000 of the amounts authorized as the United States contribution to the United Nations Relief and Rehabilitation Administration.

Resolution on children under UNO

The National Commission on Children in Wartime, impressed with the need for continuing international cooperation in measures to advance the health, education, security, and welfare of the children of the world as our best hope for a lasting peace, expresses its gratification in the progress already made in setting up the Economic and Social Council of the United Nations Organization and certain other specialized organizations, including the United Nations Educational, Scientific, and Cultural Organization. It urges prompt action to establish international organizations dealing with health and social welfare and the formation of a standing joint committee on children and youth, composed of representatives of specialized organizations related to the Economic and Social Council, to center attention on their needs and promote efforts in their behalf.

Resolution on Pacific Islands

The National Commission on Children in Wartime, recognizing the importance of full provision for the welfare of the children of the Pacific Islands now under United States control, an area of the world which has suffered greatly from the devastation of war, urges prompt formulation of policies for the guidance of those responsible for the administration of these islands, which will assure the progress of the population, especially the children.

Reprints available on request

YOUTH EMPLOYMENT HIGH

• Wartime child-labor problems are continuing. The high level in child labor and youth employment that was reached during the war has not been reduced to any great extent since VJ-day. The latest available figures indicate that the total number of boys and girls 14 through 17 years of age at work has not moved as far back toward prewar levels as might have been expected, though in most places decidedly fewer employment certificates or work permits are being issued for boys and girls of these ages to go into new jobs.

Unpublished estimates by the Bureau of the Census for November 1945 show approximately 2½ million boys and girls 14 through 17 years of age at work in full-time or part-time jobs. This figure represents about 900,000 workers 14 and 15 years old and about 1¾ million 16 or 17 years old. In the preceding April, it was estimated that 3 million boys and girls 14 through 17 years of age were at work.

The number of children obtaining employment certificates or work permits is a rough indication of the number taking jobs for the first time. According to preliminary reports sent to the Children's Bureau from States and cities throughout the country, there was a drop of 40 to 50 percent in the period September through December 1945, as compared with the same months in the previous year. But such figures as are available show large numbers of children still at work. In Philadelphia, for example, the number of certificates issued for boys and girls going into new jobs in the last 4 months of 1945 dropped more than 40 percent compared with the same months in 1944. Yet January 1, 1946, found 29,000 employment certificates outstanding for boys and girls 14 through 17 years of age at work on that date. Though this figure was 30 percent lower than the one for the previous New Year's Day, it was still six times as large as the number outstanding January 1, 1940, and twice as many as on January 1, 1942.

The figures from both these sources—employment-certificate reports and census estimates—reflect the fact that employment of young workers in industrial jobs may be going down faster than it is in agricultural and service jobs. It is these latter types of employment that are often outside the certificate requirements of State laws.

The downward trend of high-school enrollment that accompanied the wartime increase in child labor was apparently checked before VJ-day, and on the whole there is little evidence of any significant change in the fall of 1945.

Available information indicates that jobs for young workers are increasingly in the less desirable work places and in low-paid jobs. On all sides there is evidence of changes in the labor market for young workers. Employers' requirements for qualifications of workers, in terms of experience, education, and age, are rising. The demand for young workers at this time is coming chiefly from service industries. In New York City, for instance, there are practically no openings reported for beginners in electrical work, radio, woodwork, machine operation, automobile repair, or work as truck helper or truck driver. From many cities come reports that openings for part-time jobs are fewer.

At the same time, violations of child-labor standards continue in serious numbers, according to reports from both State and Federal inspectors. During the last 6 months of 1945 the number of children found to be employed in violation of the child-labor provisions of the Federal Fair Labor Standards Act was 3,787—more than four times as many as in the corresponding period in 1940, though somewhat fewer than in the corresponding period of 1944 and about the same as in 1943.

On the other side of the picture, unemployment of out-of-school young people has become a problem in some places. For instance, in Detroit, during the week of December 3, 1945, in a cross-section group of 59 young people 15 through 19 years of age, out of school and in the labor market, 11 were unemployed—nearly one-fifth. However, comparatively few of the applicants for unemployment compensation, in places from which figures are available, are young people.

These facts point to the immediate importance of:

1. Efforts to strengthen child-labor protection under both State and Federal laws, and restoration of peacetime standards both as to working conditions and as to the extent to which employment of boys and girls 14 through 17 years of age is suitable or desirable in relation to their need for education and the Nation's need for an educated citizenry.
2. Good counseling and placement services for all young people.
3. A high level of employment opportunity in the national economy—high not only in availability of jobs but also in the level of wages, working conditions, and opportunity for advancement. Lacking this, young people, without the priority or seniority privileges of veterans and established workers, will be among the greatest sufferers.

Reprints available on request

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LABOR LEGISLATION IN CANADA; a historical outline of the principal Dominion and Provincial labor laws. Legislation Branch, Department of Labor of Canada, Ottawa, 1945. 33 pp.

This publication gives a picture of the development and present status of labor laws in the Dominion of Canada. Sections of particular interest to persons concerned with child labor and the employment of youth are: Minimum age for employment, maximum hours of labor, and vocational education and apprenticeship.

Labor standards in the various Provinces are summarized in the appendix; among the subjects of these standards are: Minimum school-leaving age, minimum age for employment, and maximum hours of work in mines, factories, and shops.

AMERICAN ACADEMY OF PEDIATRICS STUDIES CHILD-HEALTH SERVICES

● What health services are available to the children of the United States? How good are these services? And how can they be improved and extended?

The American Academy of Pediatrics is seeking the answers to these questions as a step toward achieving the broad objective that was set up at the Academy's 1944 annual meeting: "To make available to all mothers and children in the United States all essential preventive, diagnostic, and curative medical services of high quality, which, used in cooperation with other services for children, will make this country an ideal place for children to grow into responsible citizens."

In order to know more about what child-health services and facilities exist in each of the States and to evaluate the quality of these services, the Academy has begun a comprehensive study, reaching into every hospital, every medical school, and the private practice of every pediatrician and general practitioner in the United States. At the Academy's request, the Public Health Service and the Children's Bureau are assisting in the study.

A study made by physicians

This is a study that is being organized and carried out by physicians. In each State the pediatricians, under the leadership of the State chairman of the Academy of Pediatrics, will be the group responsible for the work, and will assemble the data with the help of a full-time paid staff.

Months have been spent in planning the questionnaires, testing them, and making other preparations. Part of the groundwork has been a "pilot study," made in one State, which may serve as a guide to other States, although the pattern will be varied in other States to meet different conditions. The actual study is beginning this spring; and it will be at least 2 years before all the State committees have completed their surveys.

Since the Academy believes that in any study of the health of children it is of basic importance to know what pediatric education the physicians who may attend the children have received, it proposes to include in its inquiry a study of the medical schools in the United States. The Canadian members of the Academy have requested that their schools be studied also.

The study of medical schools is the only part of the investigation that will not be done on a State basis; instead, it will be done by geographic regions. Since the present school year is half over, it is expected to begin this part of the study in the fall.

Where the pediatricians of the country are located will be studied; also the location of the general practitioners and the specialists whose fields are important in the care of children.

General practitioners will be asked to estimate the amount of time they devote to the care of children, and to state their postgraduate training in pediatrics.

It is hoped also to gather data from pediatricians on the number of cases carried at a time, through data on the children seen during a definite period, whether at the child's home, at the doctor's office, at a hospital, or in consultation.

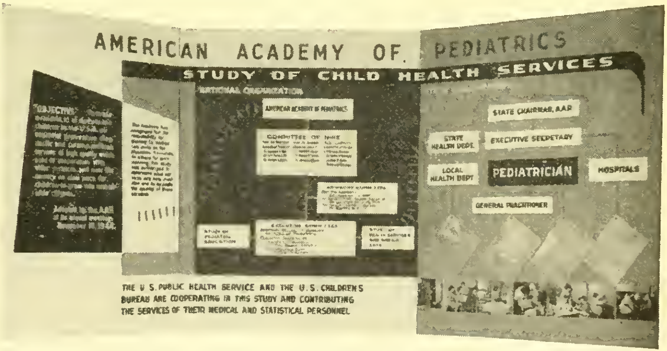
Avoid duplication of hospital study

Hospital facilities, including out-patient clinics and laboratories, will be considered, with special attention to pediatric care and care of the newborn. Since a comprehensive study of hospitals by the Commission on Hospital Care is already under way, arrangements have been made to use material from the commission's survey and to supplement it with data especially on care of children.

Both public and private child-health services will be studied with regard to extent and quality. Some of the information on these health services for children can be supplied by State health agencies; some will have to be gathered directly.

The Academy hopes that the study will stimulate local groups to review the services in their own communities as a background for local planning.

When the study has been completed the results will be presented in a factual report that will be available to all who care to use it.


AMERICAN ACADEMY OF PEDIATRICS
STUDY OF CHILD HEALTH SERVICES
NATIONAL ORGANIZATION
AMERICAN ACADEMY OF PEDIATRICS
COMMITTEE OF NINE
STATE CHAIRMAN, A.A.P.
STATE HEALTH DEPT.
EXECUTIVE SECRETARY
LOCAL HEALTH DEPT
PEDIATRICIAN
HOSPITALS
GENERAL PRACTITIONER
THE U. S. PUBLIC HEALTH SERVICE AND THE U. S. CHILDREN'S BUREAU ARE COOPERATING IN THIS STUDY AND CONTRIBUTING THE SERVICES OF THEIR MEDICAL AND STATISTICAL PERSONNEL

Photograph by James B. Lindley for Department of Labor

ORGANIZATION of the study of child-health services in the United States, now being carried out by the American Academy of Pediatrics with the cooperation of the Public Health Service and the Children's Bureau, is shown in this exhibit. The exhibit was shown at the Academy's annual meeting, held at Detroit, Jan. 14–18, 1946.

CHILDREN ACQUIRE NEW PARENTS

Recent increases in adoptions emphasize need for adequate adoption procedures

by *JOSEPH L. ZAREFSKY*

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Division of Statistical Research
U. S. Children's Bureau

- Adoption of a child is the process through which the child legally acquires one or two new parents. It is ordinarily thought of as the way in which a child becomes a member of a family with whom he has no immediate blood ties. There are instances also in which, because of tangled marital situations, previous guardianship, or the parent's desire to assure legitimacy to a child born out of wedlock, children are adopted by their natural parents.

One purpose of adoption is the protection of the child. Although the legal aspects of this protection can be carried out only by the courts, the determination of the child's needs and the evaluation of proposals for meeting these needs are the proper functions of a child-welfare agency. Yet many children are adopted without the prior knowledge of, or consultation with, the department of welfare—the State agency most directly concerned with the welfare of all children—or any other recognized child-welfare agency. In almost all States there are some children for whom adoption plans are made which first come to the attention of the State department in the form of a court notification that an adoption petition has been filed.

For an intelligent campaign to establish and maintain adequate adoption procedures in all the States one of the basic needs is information showing the problems involved in the current procedures. However, even the number of children adopted each year in the United States is not known because most States have no provision for the central collection of such statistics. In about half the States the department of welfare can obtain statistics on adoption proceedings because it (or its authorized agencies) has the legal responsibility to investigate petitions for adoption or because it has established working relationships with the courts empowered to act on such petitions. Late in 1945 the Children's Bureau obtained from 22 of these States[1] (including three-eighths of the estimated 1943 population under 21 years of age in the United States) information on the number of children for whom adoption petitions had been filed in 1944 and on selected identifying data relating to the children and their placements.

Volume of adoption petitions

These 22 States, representing all sections of the country, reported a total of more than 16,000 children for whom adoption petitions had been filed. On the basis of these data it is estimated that such petitions were filed for approximately 50,000 children throughout the country in 1944. In proportion to the population under 21 years of age in the State, the number of children for whom petitions were filed in Oregon was more than nine times that in North Carolina, the States reporting the highest and lowest rates, respectively. The Southeastern States, with the exception of Florida, reported the lowest number of children for whom petitions had been filed in relation to their child populations. These State-to-State variations are discussed in the complete report of this study, which is being prepared for later publication. This statement is concerned with only two aspects of the findings, the increase in adoptions by stepparents and evidences of the need for improved adoption laws, procedures, and services.

Adoptions increasing

One of the most significant developments in the field of child welfare has been the great increase in adoptions during recent years. An earlier Children's Bureau report by Mary Ruth Colby, "Problems and Procedures in Adoption" (Pub. No. 262, 1941), furnishes comparable statistics for six States on adoption petitions filed in 1934. In most of these States the number of children for whom adoption petitions were filed in 1944 is more than three times as great as in 1934.

The increase in adoptions by stepparents[2] underlies the great increase in adoptions, although adoptions by other relatives and by persons not related to the child also have increased markedly during recent years. In the six States for which comparable data are available the proportion of children being adopted by stepparents increased from 17 percent in 1934 to 41 percent in 1944. The great increase in stepparent adoptions undoubtedly represents in part war-stimulated legalization of family relationships that in many instances had existed in fact for years. The disruption of home life occasioned by service in the armed forces probably has been an incentive to the formalizing of existing family ties. It would be of interest to know how many of the situations in which stepparents or other relatives are petitioning to adopt children can be traced to war deaths and the break-up of homes due to war conditions, but data of this nature are not now available.

The great increase in stepparent adoptions, both in absolute numbers and as a percentage of all adoptions, affects all aspects of the adoption picture. The adoption of children by stepparents is almost always undertaken without the aid of an agency, and frequently petitions filed by stepparents are not subjected to the same study as those filed by persons not related to the child. Available data indicate that children being adopted by stepparents and other relatives are generally older than other children being adopted, and are more frequently children who were born in wedlock. Finally, courts almost routinely grant adoption decrees requested by stepparents.

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[1] Actual or estimated data were received from Alabama, Arkansas, California, Connecticut, Delaware, Florida, Georgia, Indiana, Iowa, Kansas, Louisiana, Minnesota, Missouri, New Hampshire, New Mexico, North Carolina, North Dakota, Oregon, Rhode Island, Vermont, Virginia, and West Virginia.

[2] This group probably includes a small number of children being adopted by their natural parents.

Safeguards are needed in adoption procedures

The child and his adoptive parents, as well as his natural parents, should have the maximum protection possible in the process of legalizing a new family relationship. The need for such protection is indicated by the following analysis of the detailed information available for 15 of the 22 States that reported more than 9,000 of the children for whom petitions had been filed in 1944.

Many independent adoptions are by nonrelated persons

Slightly more than a quarter of the children for whom petitions were filed in 1944 had been placed in the adoptive home by a placement agency; another quarter had been placed without the aid of an agency by parents, friends, relatives, physicians, lawyers, or others; the remainder were being adopted without the aid of an agency by relatives or by persons with whom the child had been living. If only children being adopted by nonrelated persons are considered, the importance of independent placements is indicated by the fact that more than half of these children had been placed without the aid of a recognized child-welfare agency.

Placement of a child for adoption by a competent child-welfare agency is one assurance that adequate safeguards are being observed for the child, for his natural parents, and for the adoptive parents. Agencies provide this protection by studying the child, investigating the status of the natural parents and of the prospective adoptive home, and supervising the placement during a waiting period. This basic and elementary assurance was lacking for more than half the children (and their parents) for whom adoption proceedings were instituted by nonrelated persons in 1944 in these 15 States. Observance of other desirable adoption procedures cannot completely compensate for this shortcoming. Even in States requiring the investigation of adoption petitions by the department of welfare or its authorized agencies before the court takes action on the petition, it is frequently difficult to make negative recommendations when a child placed independently has been living with the adopting parents for a long time and his status in the family has been accepted by him, by the adopting parents, and by the community.

Most of the children are very young

Another indication of the need for adequate safeguards in adoption placements and procedures is the fact that most of the children are very young, as shown by the following age distribution of the children (8,764) for whom this information was available in the 15 States previously mentioned:

Age at filing of petition	Percent
Total	100
Under 6 years	62
Under 6 months	17
6 months, under 2 years	21
2 years, under 6 years	24
6 years, under 14 years	26
14 years, under 21 years	12

Inasmuch as almost half of these children were being adopted by stepparents or other relatives (and these children generally are older than others being adopted), the proportion of young children being adopted by nonrelated persons was even greater than is indicated by these figures. It is desirable, of course, that an adopted child begin his life in his new family at an early age so that he may have the benefits of a stable and affectionate family relationship in his formative years, but it is difficult to evaluate a child's developmental potentialities when he is under 6 months of age. In order to make a satisfactory placement fully meeting the child's needs and to allow his natural parents sufficient time and assistance in reaching their decision free from pressure at least 4 to 6 months' time is needed. It is

NELL is getting acquainted with the family that wishes to adopt her. After a trial period has shown that she fits into the family circle, legal adoption will be requested.

Photograph by Philip Bonn for Children's Bureau

questionable, therefore, whether all the 1,485 children who were under 6 months of age when petitions were filed in their behalf (indicating that they had been placed at even an earlier age) in these 15 States had the protection afforded by insistence on recognized and desirable procedures in adoption. Moreover, the natural parents of these children, who were undertaking to sever the parent-child relationship, and the adopting parents, who were contemplating the establishment of such a relationship, were probably deprived of the protection they also should have had.

Children born in wedlock

Adoption is popularly identified with illegitimacy. However, 42 percent of the children for whom petitions were filed in the 15 States in 1944 were born in wedlock; in 4 States they outnumbered the children who were born out of wedlock. More than half (55 percent) of the children born in wedlock came from homes that had been broken by divorce, desertion, or separation; 32 percent had lost one or both of their parents by death. Undoubtedly a large number of these children were being adopted by a stepparent who, by marrying the surviving parent or the parent having custody of the child, had already assumed parental responsibilities for the children whom they were petitioning to adopt. However, a sizable number of these children were being adopted by nonrelated persons.

The natural parents of nearly 300 children who were being adopted were married and living together at the time the petition was filed. The circumstances in each of these situations merit further study in the individual States to determine the factors underlying the termination of these parent-child relationships. The study of adoptions in 1934, previously referred to, indicated that in some similar situations limited financial resources, together with a large number of children, had influenced some parents to consider adoption as a means of providing care for one or more children. That this unfortunate situation still persists in some localities is indicated by the comment from one State with a large Spanish-speaking population that adoption by other relatives (especially grandparents) is one method of care for children in large families. Other situations in which children born in wedlock were being adopted (in 1934) included those in which one or both parents were in ill health or in which the parents had been married shortly before or after the birth of the child and were overcome by social disapproval of this situation. These certainly represent situations calling for the greatest use of professional child-welfare skills, situations which, with skilled help, might have been resolved otherwise.

Children born out of wedlock

Children being adopted need to be safeguarded by adequate procedures whether born in or out of wedlock. But in the case of children born out of wedlock the need for services is most compelling. More than two-thirds of the children placed independently of an agency in the 15 States (exclusive of those being adopted by relatives independently of an agency) were born out of wedlock. The unmarried mother needs to be assisted skillfully and without pressure to regain her emotional equilibrium and to decide what is the best plan for herself and her child. If she decides to give up her child for adoption, time is needed for adequate study of the child and for a careful placement. Only in this manner can the child be assured of a satisfactory placement, his mother comfortable in the decision she has reached, and the adopting parents secure in the knowledge that everything humanly possible has been done to establish their new parental status on a sound base.

For the unmarried mother, as well as for the adopting parents, the attractive feature in these independent placements usually is the speed and secrecy with which the arrangements are consummated. Often, in addition, the mother's confinement expenses are paid by the adopting parents. That these placements are usually arranged with the best of intentions does not mitigate the disastrous outcomes which may result. Our daily newspapers all too frequently carry stories of legal action brought by a mother to regain the custody of a child after having consented originally to its adoption in the period of emotional and physical stress after his birth or, in some cases, even before his birth. Less publicized but equally unfortunate are the situations in which, as the adopted child grows up, the unsatisfactory placement becomes painfully apparent. The skilled service, to both natural and adopting parents that is involved in placements for adoption by recognized child-welfare agencies, is directed toward avoidance of such situations.

It is evident that we have a long road to travel before all parties to the adoption of a child are assured of all the safeguards that should accompany the legal establishment of a new family relationship. The goal to be achieved is the maximum use of competent agencies in providing service to the natural parents and in placing the child for adoption. An important step in this direction will be recognition in all the States of the responsibility of the department of welfare or its authorized agencies for investigating all petitions for adoption and recommending to the courts the most desirable action to take in each situation. Most courts that are empowered to grant adoption decrees do not have the time or staff required for the intensive study entailed in assessing the adequacy of adoption placements. The investigation by the department of welfare or its authorized agencies is an important factor in implementing the protection of the child, which is one of the purposes stated and implied in these legal proceedings. Departments of welfare, and child-welfare agencies generally, must therefore build community understanding and support of this service by adequate interpretation.

Reprints available on request

PLANNING SERVICES FOR CHILDREN TO SUPPLEMENT THE HOME AND SCHOOL

• Planning for the needs of children is of vital importance to the future security, welfare, and happiness of our people. The strength and stability of our country depends on giving children the best possible chance to become fully qualified citizens. The war has deepened the general understanding of the necessity for conserving child life. This trend has been accelerated in many communities through recognition of the child-care needs created by employment of mothers.

In the transitional and postwar periods many mothers will continue to be employed or will enter employment. In other homes congestion, illness, or other factors will make it imperative that young children have opportunities for outside experiences and companionship of other children for a part of the day. The values of group experiences for young children regardless of home conditions are becoming more fully recognized, as is the principle that for children of all ages schools should provide varied programs adapted to individual needs and complementing home experience.

It is important for States and communities to distinguish clearly between educational services provided through the schools and available to all children and child-care services needed to supplement what the home and school together can make available. Recreation and youth-serving agencies will also have a part in a comprehensive program.

Infants, children under 6 years of age, children of elementary-school age, and young adolescents have varying needs which should be met in a comprehensive program for children. Some will require homemaker service in the home; others, care in foster-family day-care homes; and others, group care in nursery schools, school-age centers, or day-care centers. For some of these types of care there is need for more experimentation before it can be determined what services are best under varying circumstances.

In each community there needs to be a representative planning body for children, to work out ways by which schools, social agencies, and other community groups, both public and private, together can be equipped to meet all needs. It is important that parents participate in planning services for their children, through representation on planning bodies, advisory committees, individual consultation, participation of parents in child-care programs, and other means.

The State and local departments of health, education, and welfare will find it desirable to develop joint policies covering services to be provided for children through these channels.

Some States already have legislation which permits planning for comprehensive services to children and the use of public funds in developing these services. Other States need to provide or strengthen such legislation. Because of the necessity of safeguarding children for whose care independent arrangements are made by their parents, such legislation should include provisions for licensing of independent boarding homes and day nurseries by State departments of public welfare. Similarly protection should also be afforded children attending nursery schools under private auspices through registration of these schools with State departments of education, so that they may obtain professional advice and assistance in the maintenance of standards.

The following principles are suggested as guides in the development of State and local programs for children and in the formulation of State legislation delegating authority and providing funds to the appropriate State agencies to make available such services as part of their regular programs. Assistance from the Federal Government may also be needed.

Educational services to be provided by schools

1. Public schools have been established to provide educational programs for all children. Educational programs have been expanded and special services offered during the emergency to meet the needs of children in war areas.

2. Boards of education are now formulating plans for educational programs in the postwar years and considering the continuation of those services offered during the emergency which also have value in the long-term educational programs. Recognition is being given to services which are of special value in promoting mental and physical health and preventing social maladjustments in later years. The following services for children, among others, are significant in the expansion of educational programs:

a. Educational services for children under 6.—Nursery schools and kindergartens are included as units of the elementary school to insure continuous educational progress of young children upon school entrance. These programs for young children under public-school auspices should be available for all children whose parents desire them.

b. School-age centers.—It is desirable that programs offering worthwhile experiences for children of school age be provided as a school service during the hours such services are needed by children and their families. School-age centers are related to, and a part of, the school program to supplement a child's home life.

c. Programs for parents.—Educational programs for young children can be effective only if a program is planned with parents which enables them to develop better understanding of children and to grow in their skill in applying child-guidance principles.

d. School lunches.—Nutritious lunches should be available at school to all children. Related to the provision of school lunches and of vital importance in the health program is the development of good food habits and attitudes through teacher guidance in the classroom and lunchroom.

3. Authority should be delegated to the State education department for the supervision and development of these educational programs for children. State funds should be provided to supplement local school funds for the continuance and extension of services for children as needed.

Services to be provided by social welfare agencies

1. Even though educational services available for all children are developed as outlined, there will still be children whose needs are not met by these services. Included in the group for whom other provisions may be required are some of the children whose mothers are employed or who for other reasons, such as illness, cannot receive the care and supervision normally available in the home. Provision of services to supplement home care and educational programs available in the schools is the responsibility of social-welfare agencies and particularly of public-welfare departments.

2. A program for day care should be sufficiently broad and flexible to meet the needs of children of all ages and of varying home conditions. It should include information and counseling services as well as provide for various types of care such as day-nursery care and other forms of group care, foster-family day care, and homemaker service.

a. Counseling service is essential as a part of a day-care program to help mothers in planning care for their children and in making necessary arrangements.

b. Day-nursery and other forms of group care will be required for mothers whose hours cannot be adjusted to the school program or who for other reasons find the service better adjusted to their situation. A constructive developmental program should be included in such day-nursery care. Programs for school-age children both before and after school and in vacation periods need to be provided if these are not available through the schools.

c. Foster-family day care will be needed for children under the age for group care and children who for other reasons require individual care.

d. Homemaker service is a necessary supplement to other services, particularly for temporary or emergency care such as during illness of the child.

3. State funds should be made available through the State welfare department for aid in the development of local services as part of a broad child-welfare program.

4. State departments of education and local boards of education should serve in an advisory relationship to departments of welfare in the formulation of child-development standards for day-nursery care.

Health services

The services of State and local health departments in cooperation with educational and welfare authorities are needed to assure adequate health supervision and maintenance of standards conductive to good health in all programs for the care of children.

A statement prepared jointly by the Children's Bureau and the U. S. Office of Education, Federal Security Agency.

Reprints available on request

WHEN MOTHERS ARE AWAY from home, some children stay in the street, taking their fun where they find it, whether it is safe or dangerous. Others have a day-care center to go to, and their mothers know they are safe.

Photograph by FSA

Photograph by Curtiss-Wright Corporation

IN THE NEWS

Planning for Children and Youth

California

The California Youth Committee, Robert A. McKibben, chairman, has recently been appointed by the Governor. The secretary is Karl Holton of the California Youth Authority, Washington Building, Los Angeles 13, Calif.

North Carolina

The name of the North Carolina State Planning Board's committee on security and services for children and youth has been changed to the committee on children and youth, and its membership has been somewhat expanded. Curtis Ezell of the staff of the State Planning Board, Raleigh, N. C., is acting as secretary to the committee.

South Carolina

The Governor is serving as chairman of the South Carolina Youth Conservation Committee, which he recently appointed and which held its first meeting December 4, 1945.

The committee includes: (1) A planning board consisting of representatives of the State departments of health; welfare; education; law enforcement; forestry; agriculture; labor; research, planning, and development; of the State Library Board; and of the extension service of the University of South Carolina; (2) a youth-advisory council including professional and lay representatives of organizations and institutions and young people, which is divided into six study committees (health, education, social services, labor, recreation, and religion); and (3) a legislative survey committee, of which Senator Calhoun Mays of Greenwood, S. C., is chairman, and which includes in its membership one other senator, a member of the house, a college professor, a judge, a clubwoman, and the chief of the division of child welfare, State Department of Public Welfare.

The six study committees will make a preliminary report to the Governor, in April, of conditions in the State relating to children. They will work with many groups and organizations in all parts of the State, and will make recommendations that can be carried out now and those to be carried out in the future. After the State-wide study is made, a guide will be issued that can be used in local communities in studying actual local conditions.

The members of the planning board and the committee chairmen will be available as speakers and organizers in local communities. The material developed will be available to all groups for study in any part of the State.

Edith Rockwood.

Georgia Enacts 16-Year Minimum-Age Child-Labor Law

Georgia's legislature has just enacted child-labor legislation establishing a minimum age of 16 for employment in factories and certain other mechanical establishments; and also for any employment, except in agriculture and domestic service, during school hours. Fifteen other States now set 16 years as the basic minimum age for general employment. In enacting this legislation Georgia brought its child-labor laws into general conformity with its school-attendance law, which was passed last year and which requires attendance up to the age of 16 years.

The child-labor bill, sponsored by the child-labor section of the youth division of the Georgia Citizens Council, was introduced, and passed by the Senate, in 1945. In the 1946 legislative session the house passed the bill with two amendments, which were accepted by the senate. The child-labor section, under the leadership of Mrs. Francis Dwyer, was successful in obtaining and coordinating extensive support for the bill. Private agencies and organizations, labor groups, employer groups, and many public officials and private citizens not only endorsed the bill but gave it enthusiastic support.

International Council Meets at Montevideo

Mrs. Elisabeth Shirley Enochs, Director of the Inter-American Cooperation Unit of the Children's Bureau, represented Katharine F. Lenroot, Chief of the Children's Bureau, at the regular annual meeting of the International Council of the American International Institute for the Protection of Childhood at Montevideo, Uruguay, March 14, 15, and 16.

The Government of the United States adhered to the Institute in 1928, and Miss Lenroot has been the permanent representative of this country on the International Council or Governing Board since that time. Participation by this country and attendance at annual and extraordinary meetings of the Institute are arranged by the Department of State.

The agenda of the meeting this year included revision of the statutes, establishment of departments of education and social service, and discussion of plans for the Ninth Pan American Child Congress.

Social-Statistics Supplement Will Soon Be Issued

Another social-statistics supplement to *The Child* will soon be issued, entitled, "Changes in Volume of Health and Welfare Services, 1942–43." This report, which is written by Joseph L. Zarefsky, suggests the pattern of changes in provision of health and welfare services in our second war year, as shown in data reported by 43 large urban areas. It includes also a tabulation for 1944.

As soon as this supplement has come from the press, a limited number of copies will be available upon request.

Welfare Council of New York City Promotes Visiting Housekeeper Service

The Welfare Council of New York City, which is the central planning and coordinating body for social services in that city, has a five-point program to promote visiting housekeeper service: (1) To bring about full development of housekeeper service under both voluntary and public auspices, (2) to determine the volume and nature of the existing need and make other fact-finding studies, (3) to insure coordination of services, (4) to plan demonstrations and set standards for improved procedures, and (5) to promote public understanding and support of housekeeper service.

The Welfare Council's interest in promoting housekeeper service dates back to 1935, when it helped to form, and guided, a WPA project through which persons who would otherwise have had to be cared for in institutions were enabled to remain in their own homes.

Spanish - Speaking Peoples Program Is Transferred

According to an announcement from the Institute of Ethnic Affairs, Inc., the "Spanish-speaking peoples program" has been transferred from the Office of Inter-American Affairs to the institute.

"We shall continue," the announcement says, "to work with local, State, and Federal agencies in the accomplishment of these tasks and to seek the active cooperation of all interested groups."

For Outstanding Service

Leonard Mayo, chairman of the National Commission on Children in Wartime, president of the Child Welfare League of America, and dean of the School of Applied Social Sciences of Western Reserve University, was awarded the annual Parents' Magazine medal for outstanding service to children at a luncheon given by the editor, Mrs. Clara Savage Littledale, at Washington, February 7.

FOR YOUR BOOKSHELF

THE STEPCHILD, by William C. Smith. Reprinted from American Sociological Review, April 1945. 6 pp.

Finding almost nothing on stepchildren and their problems in the literature of child development, the author of this article contributes a few items upon the subject.

Some inadequate statistical samples, he says, indicate that about 6 percent of children in this country have stepparents. Maladjustment of stepchildren is not necessarily connected with the presence of a stepparent in the home, the author finds, even though the breaking of the family and the introduction of a substitute parent may create definite problems that stem from the step-relationship.

MIGRANT BOYS IN WARTIME AS SEEN BY U. S. O. TRAVELERS AID, by Margaret Blenkner and Jeannette M. Elder. Social Service Review, September 1945 (vol. 19, pp. 324–342).

During the war so many migrant boys 16 to 20 years of age were coming to the U. S. O. Travelers Aid units in overcrowded wartime communities that the National Travelers Aid Association in 1944 undertook to study the problem. The 20 U. S. O. Travelers Aid units that had the highest case loads of unattached civilian boys 16 to 20 years old in the first 6 months of 1944 were selected for this study. Information about 2,506 migrant boys needing casework services was brought together and analyzed.

This report documents many of the problems that were observed by Mary Skinner and Alice Scott Nutt of the Children's Bureau in the spring of 1943. ("Adolescents Away From Home," in the Annals of Political and Social Science, Nov. 1944, pp. 51–59.)

The Travelers' Aid report sums up its picture of a migrant boy in wartime in these words:

"He was younger than the transient youth of the depression and somewhat more likely to be a Negro, but he came from very nearly the same places, and he migrated to much the same areas as in the depression. He was much more likely to be employed than his predecessor, but he found difficulty in managing or saving his money and frequently needed financial assistance. His movement was a reflection of the increased mobility of labor in the war years, but it was also a reflection of unsatisfactory or destructive family and community relationship in his home town. He was less likely to be hitchhiking or riding a freight train than in the depression years, yet was still liable to be arrested as a vagrant and either jailed or told to 'move on out of town.' He lived—if he found housing at all—in public dormitories or in 'flop-houses' and cheap, single-men's hotels. He needed, and sometimes sought, counseling and case-work services, but his whole environment was usually so destructive and so conducive to flight that often he would not wait until the help he needed could be appropriately given. He was one of the last persons drawn into the war labor market and is one of the first to go as reconversion begins. He was a source of great concern to the U. S. O. Travelers Aid workers, who saw him and wondered what would happen to him when peacetime came again." E. S. J.

SOCIAL WORK YEAR BOOK 1945; a description of organized activities in social work and in related fields, edited by Russell H. Kurtz. Published biennially. Russell Sage Foundation, New York, 1945. 620 pp.

Among the subjects of topical articles not treated in the previous edition are: Camping, Employment Services, Foreign Relief and Rehabilitation, Labor and Social Work, Seamen's Services, and Social Insurance.

RECENT C. B. PUBLICATIONS

SERVICES FOR UNMARRIED MOTHERS AND THEIR CHILDREN. U. S. Department of Labor, Children's Bureau, Washington, 1945. 18 pp.

This publication is a joint statement by the Children's Bureau, the Bureau of Public Assistance of the Social Security Board, and the American Red Cross, three agencies concerned with health and welfare programs reaching all States and their local jurisdiction. It presents broad general principles, which are applicable anywhere in the United States and to any unmarried mother and her child. The purpose of the material is to encourage further coordinated planning by States and local communities for fullest use of all services and facilities and to stimulate provision of needed resources.

FACTS ABOUT RHEUMATIC FEVER. Bureau Publication 297. U. S. Department of Labor, Children's Bureau, Washington, 1945. 9 pp.

Here are answers to a number of questions that people ask about rheumatic fever in children, such as, Can it be prevented? What are the signs? Why is it so serious? Why are State and community programs for the care of rheumatic children necessary? Who takes care of the children under the State program?

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The CHILD

CHILDREN'S BUREAU • U. S. DEPARTMENT OF LABOR

- CHILDREN ARE HUNGRY
- 10 YEARS PROGRESS IN STATE CHILD-WELFARE SERVICES
- WORK OF NURSE-MIDWIVES

U. S. SUPERINTENDENT OF DOCUMENTS
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The CHILD

MONTHLY BULLETIN

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The picture on the cover, of a little girl in Greece, is an UNRRA photograph.

The drawings on pp. 158–161 are by Philip Curtis, Washington, D. C.

U. S. DEPARTMENT OF LABOR
L. B. Schwellenbach, *Secretary*
CHILDREN'S BUREAU
Katharine F. Lenroot, *Chief*

CHILD HEALTH DAY, 1946

★ ★ ★

BY THE PRESIDENT OF THE UNITED STATES OF AMERIC

A PROCLAMATION

WHEREAS the Congress by joint resolution of May 1 1928 (45 Stat. 617) has authorized and requested the Pres dent of the United States to issue annually a proclamatio setting apart May 1 as Child Health Day:

NOW, THEREFORE, I, HARRY S. TRUMAN, Presiden of the United States of America, in recognition that the healt of American children, like their education, should be accepte as a definite public responsibility, do hereby designate th first day of May this year as Child Health Day.

And I call upon the people in each of our communities t pledge themselves today to review their community health an medical-care services to see how well these services meet th needs of all our children in the light of the goals of the na tional health program; and to organize a definite plan t achieve within the coming year at least one improvement i community health services which will contribute to the bett health of children.

IN WITNESS WHEREOF I have hereunto set my hand an caused the seal of the United States of America to be fixed.

DONE at the City of Washington this thirteenth day April in the year of our Lord ninetee hundred and forty-six, and of th Independence of the United State of America the one hundred an seventieth.

Harry Truman

By the President:

James F Byrnes
Secretary of State

Publication of The Child, Monthly Bulletin, with Social Statistics supplements from time to time, was authorized by the Bureau of the Budget, May 12, 193 under Rule 42 of the Joint Committee on Printing, to meet the needs of agencies working with or for children for a regular channel of information on current deve opments, activities, policies, and programs for maintaining the health of mothers and children, providing child-welfare services, and safeguarding the employment youth. Address The Child, Children's Bureau, U. S. Department of Labor, Washington 25, D. C. The Children's Bureau does not necessarily assume respons bility for the statements or opinions of contributors not connected with the Bureau. The Child is for sale by the Superintendent of Documents, Government Prin ing Office, Washington 25, D. C., at $1 a year; foreign postage, 25 cents additional; single copies, 10 cents.

CHILDREN ARE HUNGRY

Out of America's abundance must come he food that will keep millions alive

y *FRANCES BALGLEY*
Reports Division
U. S. Children's Bureau

The tragedy of hunger is that it kills he mind and spirit even when it does ot kill the body. To the children of oday will fall the task of building the orld of the future. What kind of orld will it be if we abandon millions f these children now to the blight of amine?"

Sir John Boyd Orr
Director-General
Food and Agriculture Organization of the United Nations

In the small Yugoslav village f Flasenica, reached by a long ifficult climb from the Drina Valey, the village president watched s the first load of grain sent in by UNRRA was unloaded from a ruck. Turning to a stranger tanding near him he said quietly: Our children eat every other ay."

There is no way of counting the lasenicas in the world, nor of esimating the number of meals chilren are doing without. But the ars of the world echo with the cry Food!" rising from the empty ouths of hungry millions.

Hunger is a familiar specter in he wake of war. But not in the arkest thoughts of the most pesimistic experts did the realities of he present world food situation ccur. To the disruption of food roduction caused by armies of nen have been added catastrophes hich are the acts of nature. From outh America to China, to Ausralia, drought and tidal wave layed havoc with harvests in 1944 nd 1945. India, part of whose opulation is regularly on the rink of famine, lost a million tons f its normal harvest of rice and nillet to a tidal wave. In some reas of China the rice crop yielded nly 30 percent of normal, and Alerian and Tunisian wheat and arley crops were 75 percent lower han average production.

Of the 1,150,000,000 bushels of wheat needed for the peoples of the world, 250 to 300 million bushels are missing. About 8 million short tons of rice are required. Some 2 million are available. Six and a half billion pounds of fats and oils are available in the world, when about 9½ billion pounds are needed. And about 4 of the 12 million short tons of sugar required are in deficit.

In all, the world's per capita food supply in 1946 is estimated to be 12 percent below prewar production. The effects of this shortage are being felt now—during the first 6 months of this year. Huge numbers of the people of the world have become used to near-starvation and its miseries. Mass famine is just around the corner.

United States in surplus food area

Among the important wheat exporting countries, North America is the only area where wheat production has remained high during the past few years. Canada and the United States are the principal sources of surplus food production during 1945–46, and the United States was the only major exporting area where agricultural production was above average.

Of course, no modern nutritionist measures people's need for food only in calories. But calories, because they are a way to measure the quantity of food required to give a human being energy enough to keep going, are headline news all over the world.

Energy not enough

Nutritionists know that bodies, if they are to grow well and be protected from disease, must get more than energy from foods. They must have protein, vitamins, and minerals that are essential in building bones, nerves, and tissues.

Good nutrition, however, in most parts of the world today is a luxury. Just getting enough of the foods that are good in producing energy is an impossible struggle for millions of people. Cereals and fats do the best job of giving energy, so they are the first and most desperate need of starving people.

Right now, and until the 1946 harvests are gathered in, over 140 million people in Europe are being forced to subsist on less than 2,000 calories a day. About 100 million—

UNRRA MEALS ARE DISTRIBUTED every day to the children at this summer colony—one of six organized by the Italian "Catholic Action." This colony is at the Campo Dei Cavalieri Di Colombo at Via Aurelia in Rome.

UNRRA photograph

mostly city dwellers—get less than 1,500 a day. In some parts of Europe, the figures go down to 1,000 calories or less.

A good many children in Italy are getting rations of less than 800 calories a day. In parts of Yugoslavia, the intake is too low to be labeled "subsistence."

In many areas of China the food situation is "desperate." In all of China it is critical.

Caloric intake needed

Using the yardstick of calories only, the Food and Nutrition Board of the National Research Council recommends a diet of 4,500 calories for a very active man; 3,200 to 3,800 for an adolescent boy; 3,000 for a moderately active man; 2,500 for a moderately active woman, an adolescent girl, and a child between 10 and 12; 2,000 for an 8-year-old; 1,600 for a 5-year-old; and 1,200 for a 2-year-old child.

A diet of about 1,650 calories, nutritionists say, gives an adult just about enough energy to leave his bed to buy, prepare, and eat his food. This is a rough estimate of the amount of energy the "average normal consumer" in Europe gets—on which he faces the task of physical and psychological reconstruction.

"We in this country have been consuming about 3,300 calories per person per day," President Truman said on February 6.

People usually do one of two things in the face of prolonged near-starvation, such as occurred in many places during the war. They may scrounge around and eat anything available—whether or not it is generally considered edible. Or, after a length of time, they die.

Effects of wartime starvation

Greece, during the war, lost 50,000 children and 200,000 adults because of starvation. Famine deaths by the thousands have been reported from China. In 1945 alone, 35,600 children under 12 died of starvation and related causes in the Netherlands. In France, in Poland, in occupied and war-torn countries the world over, millions of children, born and unborn, and their elders, have succumbed before the simple fact—life cannot exist without food.

In these same places, many others, who were fortunate enough to survive, live on, bearing the inevitable marks.

Malnutrition, starvation's kin, has stamped its pallid print over the face of the world, leaving those afflicted ever more vulnerable.

Consider the children. Those who have survived in devastated countries have possibly fared better than adults because of parents' almost universal habit of going without food themselves so that their children lack less. Rationing has also favored children in many countries.

Great Britain in war gave children and expectant mothers top priority in rationing. Red Cross missions have offered special help to children in some regions. UNRRA programs make extra allowances of food and services to salvage the young. Countries in western Europe which do not receive UNRRA aid generally plan their estimates of requirements allowing proportionately larger rations for children. Plans and estimates on paper, however, are valueless without the realities of food.

Child-health conditions in Europe

Despite what has already been done to protect children, the outlook for their health is not bright. A round-up of health conditions in Europe published in the New York Times on March 11 reveals these facts:

In Greece, 95 percent of the population suffers from malnutrition and a resultant susceptibility to disease. A serious decline in the birth rate and increase in infant mortality has occurred. Tuberculosis is on the increase and the death rate is high.

In France, the infant mortality rate is up. In Paris, it went from 75 deaths per 1,000 in 1938–39 to 134 per 1,000 in 1944–45.

Numerous cases of malign gastro-enteritis are occurring among babies in Denmark. Often the illness is long drawn out and fat

Tuberculosis is extremely prev
lent in Italy. The infant morta
ity rate has risen to serious pr
portions. "Children in certa
parts of Naples—including the i
evitably borrowed babies used l
beggars—exhaust one's capaci
for shock and horror."

In Hungary, the most comm
diseases in children are vener
diseases, tuberculosis, and ricket
Infant mortality has risen fro
13.1 percent in 1938 to 30 perce
now.

Infant mortality in Belgium
more serious than it has been
15 years. The food ration avai
able is considered deficient aft
a child passes 6. Adolescents b
tween 12 and 17 average only
percent of normal weight. Mo
than 15,000 children are in speci
homes because of their weaken
condition.

It is true that lack of food w
not the only factor which creat
this picture. War's destruction
habitable living facilities playe
its role, too. But a supply of foo
certainly, is of prime importan
if the picture is to be brighten

How much more starvati
these children can take—acute
vulnerable as they are—is not
long-range question. They ca
take little more if they are to su
vive with any chance to grow in
normally healthy, hopeful, an
responsible individuals. The cr
sis is upon us now.

How is the world to meet th
challenge?

The urgency of the need h
swept the consciences of many
the peoples of the world. Tho
who themselves have little are sa
rificing that others may survive.

War-torn countries sacrificing

Denmark, which as an invade
country is under no obligation
supply food to UNRRA, has ju
offered that organization 10,0
horses to aid crop cultivation an
a million dollars' worth of fis
These will go mainly to Poland.

The Netherlands, but recent
delivered from flood and occup
tion, has volunteered to share h
reserve of wheat with France.

And Great Britain, havin

vithstood the blitz, the buzz bomb, nd the rocket, on the strength ained from a monotonous diet of rown bread, brussels sprouts, and ittle more, has hitched her belt till tighter in peacetime.

But the succor of the world lies n the abundance with which the orth American continent has een favored. A profound responibility for the survival of the peoles of the world rests on both anada and the United States.

Canada is making wheat availble for export to the limit of her bility. Withholding enough for nly a minimum carry-over, she is elling wheat to needy countries at rices 40 cents a bushel lower than urs. By continuing meat rationng, she is expected to supply 79 illion pounds of meat to NRRA this year. In January nd February she had already suplied more than a third of her ear's total.

nited States commitments

The United States, as its responbility, assured the Combined ood Board, an international govrnmental body whose task it is to eigh food supply against need nd allocate what is available, that would export 6 million tons of heat to UNRRA and needy countries. This amounts to 22 out of every 100 bushels from our record 1945 harvest. We had also pledged 627 million pounds of meat to UNRRA during the year, a little less than half of which was to be delivered by the end of March.

United States quota unfilled

Actually we have supplied UNRRA with only a negligible amount of the first quarter's commitment of meat. And we have not met our quota of wheat.

If production in all other parts of the world were at par, that failure would be serious enough. In the face of the present catastrophe the results of such action—or inaction—are unspeakably tragic.

The President's Famine Emergency Committee has called on the people of the United States to make a voluntary sacrifice of 40 percent of the wheat products and 20 percent of the food fats and oils they usually consume during a 4-month period ending in mid-July.

Our people have been asked to eliminate waste of bread, to substitute other plentiful foods for those most in demand for export, to re-use cooking fats, and to cut down on salad oils and oil dressings.

Complying with this request is not intended to deny children the amount of food they need for healthy growth. Neither is it expected that adults in this country who depend on wheat and cereal products for a large proportion of their diet should do without. But there are millions among our population who could easily, and indeed with benefit to themselves, deny themselves some of the excess food they eat in order that others more needy may live. Our Government is leaving it up to the conscience of each one of us to decide how much we will spare.

For every million tons of wheat the United States fails to send to Europe, 20 million people will go without bread for 6 months. Since bread is the main article of their diet, that would mean starvation. Or, if the wheat Europe has were spread more thinly, it would mean near-starvation for a much larger number.

Each boatload of wheat that reaches China saves the lives of 150,000 people.

Is it asking the people of the United States too much to request them to forgo, both literally and figuratively, the upper crust on their generous servings of pie?

Reprints available on request

RAB CHILDREN receiving milk at a school in North Africa. ilk is distributed by various agencies, assisted by the ed Cross. The children bring containers, usually tin cans.

Signal Corps photograph

CHINESE REFUGEE CHILDREN eating rice provided by the Chinese National Relief and Rehabilitation Administration. They are going home to the liberated city of Ichang.

UNRRA photograph

RECENT DEVELOPMENTS IN MATERNAL AND CHILD-HEALTH WORK IN THE U. S. S. R.

Postwar period brings better services

by ANNA KALET SMITH
Office of the Chief
U. S. Children's Bureau

• Many important developments in maternal and child-health work in the U. S. S. R. have followed the enactment of the law of July 8, 1944, on protection of mothers and children. Among them is a Government order for the construction of sufficient maternity hospitals to accommodate every city woman needing such care and 70 percent of the rural women. Eleven thousand additional maternity beds were set up within a year. Medical supervision of expectant mothers now begins earlier than previously; in some localities in the fourth month of pregnancy. Some collective farms are distributing supplementary food rations to expectant and nursing mothers. As a means of safeguarding the health of future mothers, quarterly physical examinations have been introduced by the collective farms for their girl employees and for schoolgirls; and treatment is provided in clinics, sanatoriums, and rest homes.

Instruct mothers in child care

"Mothers' schools," at which mothers are instructed in child care, have been set up in connection with numerous child-health centers. Correspondence courses are also conducted in some localities.

A new kind of institution, a "home for the mother and child," has been opened in several places. These are intended for unmarried or widowed mothers, who may remain in the home with their children for 3 months before childbirth and 3 months afterwards.

New day nurseries have been opened to accommodate at least 56,000 children. In many cities day nurseries have established separate divisions for children who are below par in health but do not need hospital care. Sanatorium-kindergartens, with physicians and nurses on the staff, have been opened to accommodate 45,000 children, who stay there from 2 to 6 months.

After-school centers

Trade unions, which are very active in health and welfare work for children, have set up in many localities after-school centers for children of working mothers. At these centers the children spend their time preparing their lessons, doing manual work, or playing, under supervision. Instruction in personal hygiene and in care of clothes, including sewing and mending, is also given; meals are served. The children are returned to their homes in the evening after the parents come back from work.

In the present intensive movement to improve children's healt much attention is given to the que tion of vacations. Permane committees on vacation camps a being organized as parts of t municipal governments. In 194 trade-union organizations set u summer-vacation camps, in whic more than 1,600,000 children we accommodated. In the same sun mer river boats were used for th first time as rest places for chi dren, who were sent on 40-day tri on the Volga River. A new ide was the introduction of winter v cations for school children. I order to assure pleasant and whol some holidays for the children i the winter of 1945–46, indoor an outdoor activities were organize in many cities on instructions fro the Central Council of Trac Unions; workers' clubs were ma available for use by children du ing the day; 100,000 school chi dren were sent for the duration c

EATING OUTDOORS is fun. **The children are at a day nursery on a collecti farm in a semitropical region of the U. S. S. R., beyond the Caucasian Mountain**

Sovfo

he holidays to rest homes and san- toriums maintained by the trade nions.

The health of employed youth s a subject of great concern on he part of the Government. In ompliance with a decree of 1944 census of young workers has been aken in a number of localities. Special physicians have been ap- ointed to examine these workers eriodically and otherwise to care or their health; treatment in linics, sanatoriums, and rest omes has been provided. Regu- ar inspections are made of the oung workers' living quarters. The number of "night rest homes" nd "night sanatoriums" for young eople who are able to work but re below par in health has been ncreased throughout the country.

Special bureau planned

For effective supervision of the oung workers' health, the Gov- rnment plans to set up a special ureau in the Commissariat of Public Health of the U. S. S. R.

A national conference of physi- ians serving in clinics for young orkers, and of representatives of ther public health agencies, held n December 1945, was devoted to he protection of young workers' ealth. The results of the exam- nations of 40,000 young workers, which were reported at the con- erence, revealed a steadily declin- ng rate of illness among them; evertheless, the conference urged xtension of medical services to ll young workers and improve- ment in their living quarters and laces of employment.

For the purpose of aiding em- loyed war orphans 14 to 16 years f age, factory committees have een established in some cities by rder of the local government. These committees aim to provide etter living conditions for the ar orphans employed in fac- ories, to improve their vocational raining, to guide their leisure- ime activities, and to help them n the solution of their personal roblems.

A comparatively new develop- ment in the field of child welfare n the U. S. S. R. is parental edu- ation. In a number of cities courses in child training, together with advice and information in individual cases, have been organized for parents by teachers and physicians.

A comprehensive project for still more extensive maternal and child-welfare services is included in the fourth 5-year plan for the reconstruction of the country.[1]

Under this plan, which has just been approved by the Government and therefore is now mandatory, the number of maternity clinics and maternity homes will be greatly increased by 1950. Each maternity clinic will have on its staff a physician, a midwife, a public-health nurse, and a social worker. There will be a 50-percent increase in the number of maternity beds. The pediatrician in each district will have charge of not more than 700 children under 3 years of age (a few years ago the country was divided into districts for the purpose of giving medical care to children). Each district is also to have two public-health nurses, who will not only teach mothers how to care for their children, but also study home conditions and help to obtain the necessary social services and legal aid. The number of places in day nurseries is to be increased by 50 percent under the new 5-year plan; for the convenience of mothers employed at night, one-third of the day nurseries will be open 24 hours a day. More extensive health services for children over 3 years of age are also part of the plan.

Much attention is given to the health of the rural population. The 5-year plan orders the establishment in each rural district of a dental clinic, a physical-therapy clinic, a combined mothers' and children's clinic, a milk station, a day nursery, and other services for mothers and children.

Sources: *Meditsinski Rabotnik, July 5, 13, 19, and 21, and August 16 and 23, 1945; Izvestia, October 23 and November 14 and 26, 1945; and Trud, November 30 and December 12, 14, 15, 18, and 22, 1945 (all of Moscow).*

Pan American Day 1946

Pan American Day, celebrated annually April 14, has become more significant in recent years as we are drawn closer to the other American Republics through projects of mutual interest and benefit.

High on the list of such projects are those on the health and welfare of mothers and children. For years the Children's Bureau and similar agencies in our sister Republics have been working together, directly and through the American International Institute for the Protection of Childhood, to promote standards that will help to make all child life in this hemisphere more secure.

In this work the Bureau has had the privilege of membership in the Department of State's Interdepartmental Committee on Scientific and Cultural Cooperation. It has had the guidance of the Pan American Union, the Pan American Sanitary Bureau, and other inter-American agencies. It has had the support of many professional organizations in developing its own inter-American program, and from its own experience it has been able to contribute to the programs of agencies that have more recently begun inter-American work.

The American Academy of Pediatrics, the American Academy of Orthopedic Surgery, and the Kellogg Foundation have developed important inter-American fellowship programs; the American Association of Schools of Social Work is promoting close relationships with schools in all the Americas; the Inter-American Hospital Association is advising on hospital construction and services; the National Conference of Catholic Charities has provided valuable field experience for Latin American social workers. To these and many others the Children's Bureau expresses its gratitude for the privilege of sharing in common undertakings that give richer significance to Pan American Day.

Elisabeth Shirley Enochs

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[1] The first 5-year plan was completed in 1932; the second in 1937; the work of the third was interrupted when the Germans invaded the U. S. S. R. in 1941.

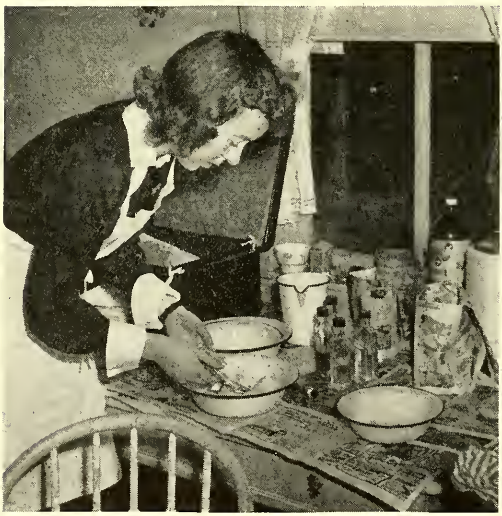
NURSE-MIDWIVES HELP TO RAISE

Photographs by Press Association, Inc.

Nurse-midwives are totally unlike the untraine midwives that "catch" babies in some parts of th United States.

The nurse-midwife has graduated from a nursin school. Besides, she has completed a 6-month cours in nurse-midwifery. As a rule she has also had public-health course at a university. She has ha some years of experience in nursing, usually publi health nursing.

As a certified nurse-midwife, she is qualified t conduct normal deliveries and to care for the mothe during pregnancy and for both mother and bab after the delivery. She does all her work unde medical direction. All patients are examined in tially by a physician; and if any complication shoul arise during pregnancy, childbirth, or postpartu the nurse-midwife calls the consulting physicia immediately.



THE NURSE-MIDWIFE covers the table with newspapers and sets up the delivery equipment. She is often obliged to use her ingenuity in improvising utensils and other necessities.

CHANGING THE DRESSING on the baby's navel. Tl nurse-midwife does this as often as is necessary. Tl dressing has been sterilized in a sealed paper wrappin

NDARDS OF MATERNITY-NURSING CARE

Certified nurse-midwives are so few—only about
0 in the United States—that only an occasional one
ves her time to attending deliveries. As the num-
r of rural physicians becomes more adequate, the
le of the nurse-midwife will be increasingly that
a specialist in maternity nursing. Those with
ditional experience in supervision and teaching
t as consultants to State health agencies in rais-
g standards of maternity nursing in the State.
ieir duties include developing educational pro-
ams for public-health nurses and supervising un-
ained midwives.

Funds used by the States for training and employ-
g nurse-midwives are provided by the Children's
ureau through grants-in-aid under the Social
curity Act.

BESIDES HER DELIVERY BAG, this nurse-midwife is carrying a suitcase of necessary articles, which are not available in this home away out in the backwoods.

ACING HER HAND under the baby and holding him only
few inches above the bed, the nurse-midwife weighs him.
e writes down his weight so that she can see how he gains.

WARMLY WRAPPED UP, the newborn baby is carried by the nurse-midwife into his mother's room. She is glad to get acquainted with him and to know that he is strong and healthy.

FOUNDATION LAID FOR BROAD STATE CHILD-WELFARE PROGRAMS

Ten years of Federal-State cooperation in providing child-welfare services

by *MARTHA WOOD*
Director of Field Services
and *MARGARET A. EMERY*
Child Welfare Analyst
Social Service Division
U. S. Children's Bureau

• When the Social Security Act was passed in 1935, making $1,500,000 available each year as grants-in-aid to help States develop their child-welfare services, only 26 States had within their State welfare departments divisions responsible for conducting or supervising child-welfare services on a State-wide basis. Although nearly all States had laws giving the State some responsibility for the care and protection of children, many States had no public service primarily for children on a State-wide basis, with the exception of a State institution for delinquent children or, perhaps, for dependent children. Only one-fourth of the States had pioneered in developing local public services for children through public county organization for child-welfare work under State leadership. In only one State was there a child-welfare program in practically every county.

Now, every State—including in that term the territories of Alaska, Hawaii, and Puerto Rico—has recognized in law its responsibility for the welfare and protection of children. Every State has a department of public welfare, or a separate division or bureau of welfare in some other State department, to carry out welfare functions including those of child welfare. Now, in approximately half the States, county welfare agencies have fairly broad legal responsibility for services to children who are dependent, neglected, or handicapped. Every State has a plan which includes public child-welfare services provided by local child-welfare workers in at least some of the counties or other local subdivisions.

This is just one measure of the progress that has been made in putting within reach of parents and children the helping hand of public servants skilled in advising on and dealing with the problems of children who are dependent, neglected, or delinquent, and children who are in danger of becoming delinquent. For 7 of these 10 years, from July 1938 to July 1945, reports on child-welfare services submitted to the Children's Bureau are sufficiently itemized to allow other counts to be taken of the gains—and losses—that have been made in this important area of social service under public auspices.

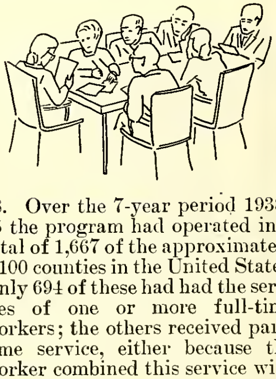
Areas helped with Federal funds

Under the law, Federal funds for child-welfare services are for use in developing State-wide services by State agencies, and local services by public agencies functioning in rural areas or in areas of "special need." The number of areas served in the 7 years fluctuated from 437 in 1939 to a peak of 551 in 1942, and then down to 389 in 1945.

An "area" in the meaning of the Social Security Act is not limited in size. It may include more than one county. The 437 areas served by workers paid from Federal funds in 1939, included, for instance, 1,120 counties. By 1942 a significant trend had set in. By then the number of counties reached was only 979. As child-welfare work has become better established, the number of counties covered in each area has tended to decrease, rather than increase. This is because the States have found that one worker could not adequately serve several counties. In the interest of better service to children and communities, the area served by one worker has been reduced in most instances to one or two counties. By 1945, the counties included in the 389 areas totaled 543. Of these, 441 were rural and 102 urban.

Wartime pressures had a decided effect on the type of area using Federal funds. At first practically all of them were rural; only a relatively small proportion were areas "of special need." The latter increased from 40 in 1939 to 104 in 1943, and dropped only slightly, to 96, in 1945.

In no year has Federal aid reached more than 37 percent of the counties of the Nation. In 1945 the percentage reached was 18. Over the 7-year period 1938–45 the program had operated in a total of 1,667 of the approximately 3,100 counties in the United States. Only 694 of these had had the services of one or more full-time workers; the others received part-time service, either because the worker combined this service with other duties or served more than one county.



Counties that discontinued use of Federal funds

A majority of the 1,667 counties that had the use of Federal funds during the 7-year period did not use these funds continuously. This was due largely to the limitation of Federal funds available and the necessity of placing emphasis on the use of these funds on a demonstration basis. In 1,198 counties, the use of Federal funds was discontinued for as long as one fiscal year or more. Reasons for this are significant. In 587 counties, in 8 States, the use of Federal funds stopped as a result of redistricting of areas to enable workers paid from these funds to do a more intensive job in other counties. In 261 counties services were discontinued because qualified staff was not available to continue services already begun. This situation occurred in 42 States. States or communities assumed financial responsibility for services initiated with Federal funds in another 177 counties in 22 States. In the remaining 173 counties, expenditures from Federal funds were discontinued for a variety of reasons: Lack of funds; greater need for service in another county; lack of community resources; lack of community interest; or a combination of several factors.

Local workers paid from Federal funds

Grants-in-aid from the Federal Government for developing local child-welfare services have gone almost entirely into services of workers. Most of them are professional staff; a few are clerical workers. Most are full-time child-welfare workers.

Effects of the war on the availability of workers show up in the number of workers. The peak year in the use of Federal funds for local services was 1942. In that year the highest numbers were reached, both in professional and clerical workers whose salaries were paid in whole or in part from Federal funds. Professional workers numbered 493 in 1939, 656 in 1942, and 535 in 1945. In the same years, clerical workers totaled 78, 110 and 65.

Fluctuations in the volume of employment of part-time workers followed a similar course, starting with 60 in 1939, increasing to 81 in 1942, and dropping to 69 in 1945. This trend reflects an increasing recognition of the fact that services if they are to be effective must not be spread thin.

In response to the wartime increase in need for child-welfare services in congested areas, the number of local workers in areas of special need increased through 1944, and dropped only slightly in 1945. At the same time the workers in rural areas decreased fairly steadily from 1942. It is a cause for concern that both in 1944 and 1945 the number of workers serving rural counties and the number of such counties served were both smaller than in any other of the 7 years.

State services paid from Federal funds

Every one of the States and Territories has taken advantage of the financial help made available by the Federal Government for extending both State and local child-welfare services. One State, Utah, participated from 1936 to 1944 and then dropped out of the program. Several States did not get started at once but have participated continuously since they did begin.

Professional workers providing State services and paid in whole or in part from Federal funds were more numerous in 1939 and 1940 than in any subsequent year. In those 2 years they totaled 314 and 323. By 1945 their number had dropped to 256. The number of clerical workers was at its peak, 105, in 1939, and declined fairly steadily to 53 in 1945. This decrease was due almost entirely to State-agency assumption of financial responsibility for clerical services.

These numbers, it must be remembered, are not indicative of the total force of workers attached to State child-welfare agencies, since a part of such services is usually paid for from State funds. The relative importance of the Federal contribution to State programs varies from State to State and from year to year.

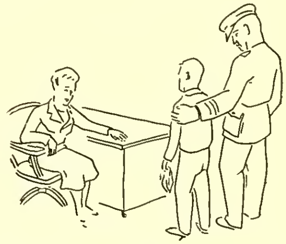
SIGNIFICANT TRENDS

Statistical measurements of social services are, of course, only one device for appraising their value to people. Qualitative factors, which sometimes do not lend themselves to arithmetical count, must also be weighed in the balance.

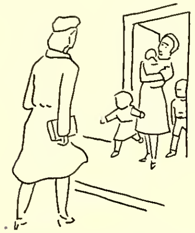
1. Expansion of local services

As the organization of local services has increased, there has been greater emphasis by many States on the development of services in every county. For example:

In ***Georgia*** from 1931 to 1937 only one to three persons were available for carrying out the child-welfare responsibilities of the State agency. When Federal funds became available, they were used to increase the State staff. At that time child-welfare consultants were assigned to districts consisting of about 15 counties each, in which they were to provide casework services to children. In the meantime, county welfare departments were being established in every county. Because of the pressure of work involved in carrying out the assistance program, the county departments were not asked to assume responsibility for child-welfare services. As these departments became better organized, the State agency gradually transferred to them the responsibility for providing child-welfare services. By 1945, the State staff was no longer assuming responsi-



bility for direct service to children but was concentrating its efforts on consultation to the regular public-welfare staffs and child-welfare workers assigned to certain of the county departments in order to help the counties provide better case-work service to children.



In ***Nebraska*** the same plan was followed when child-welfare services were first organized.

By 1939 all the case-work responsibilities that the district child-welfare staff had carried had been transferred to the county welfare departments under the supervision of the State agency staff. This plan has remained in effect since 1939.

In ***Alaska*** there was no professional staff to provide public-welfare services until the program of child-welfare services was initiated in 1938. Only one worker was employed in the beginning. Gradually staff was increased, and a worker was assigned to each of four district offices. By 1945 there were six professional workers directly engaged in providing child-welfare, family-welfare, and other public welfare services.

In other States there is still a large number of counties where public child-welfare services are not yet available. For example:

In ***Texas*** there are no county public welfare agencies having responsibility for child-welfare services except two large probation departments. At present there are county child-welfare units in only 16 of the 254 counties in the State and they are administered cooperatively by the county child-welfare boards and the division of child welfare of the State public welfare agency.

In ***Iowa*** there are no State funds for care of children in boarding homes, and the only local funds are those provided in the county poor fund. There are county child-welfare units in 11 of the 99 counties in the State. The workers in these 11 units are the only public workers giving full time to child-welfare services in local communities.

In some States, public child-welfare services are still limited to specific groups, such as children committed to the care of public agencies and children who are public wards.

2. Improvement in the standards for State and local personnel

From the outset of the program under title V, part 3, the Children's Bureau and the State public welfare agencies recognized that no program of services to children could be carried on effectively without qualified personnel. The Children's Bureau Advisory Committee suggested certain basic requirements for child-welfare positions, and minimum standards of qualifications for personnel were included in State plans. Since that time, personnel standards on a merit basis have been developed in every State.

The need for some provisions for increasing the supply of workers qualified to give services to children and also for improving the skill of workers on the job was also apparent from the beginning of the program. The use of Federal funds for educational-leave stipends for workers already employed in the public welfare program to enable them to obtain graduate professional training has been an important aid in the improvement of standards for State and local personnel.

3. Increased expenditures for child welfare

State and local funds appropriated for child-welfare programs have shown a marked increase. Instead of "drying up" these resources, the Federal grants have served to draw out additional funds. For example:

In ***Arizona*** the expenditure of State funds for the direct care of committed children (excluding foster-home care) increased from $3,257.15 in 1939 to $60,000 in 1945.

In ***Maine*** the first appropriation for supplemental funds (in addition to those for committed children) was provided in the 1944–45 biennium and was allocated for care of unmarried mothers and their babies. This was a further step in the extension of services to children without commitment.

The ***North Dakota*** Board of Public Welfare allocated $20,000 for child-welfare services for the biennium ended June 30, 1939, an increase of $4,720 over the amount for the preceding biennium. For the biennium ended June 30, 1945, $43,375 were allocated for the administration of child-welfare services.

In ***Delaware*** total expenditures for child-welfare personnel increased from $8,135.04 in 1937 to $26,547 in 1944 and expenditures for maintenance cost for children in foster homes increased from $12,773.89 in 1939 to $61,138 in 1944.

4. Expansion of State services

Not only does every State now have a department of public welfare and with one or two exceptions a child-welfare division in the State department, but in practically every State the number of staff members providing State services has increased. Here are some illustrations of growth:

Maine is one of the States which had a child-welfare division when the Social Security Act was passed. In 1936, when child-welfare services became operative, the child-welfare staff consisted of two district supervisors. In 1945 the staff providing State services consisted of a supervisor, an administrative assistant, four district supervisors, a consultant to child-caring agencies and institutions, and a psychologist.

Nebraska has had a child-welfare bureau since 1919, but with the availability of Federal funds an expansion took place in 1936 which practically amounted to a reorganization of services into an entirely new program.

Mississippi is one of the States that had no legal basis for establishment of a child-welfare division. By 1945 legislation had been passed providing this legal basis, and a child-welfare division had been developed, with a staff including a director, two child-welfare supervisors, a consultant on foster care, and a child-welfare consultant.

5. Addition of technical consultants in special fields

As basic services have been established, a number of States have developed services in special fields to aid in developing a well-rounded total program.

Technical consultation in special fields of child welfare, such as adoption, foster care, and in-service training, has been developed by several States. In 1945, 17 States included provisions in their annual plans for the use of Federal funds for the services of a psychiatrist or a psychologist. Through such services as these, the breadth and scope of State services have been expanded in many States.

6. Improvement in child-welfare laws

In practically every State new laws have been passed or old laws modified to provide greater safeguards or improved public services to children. In many States the State and local advisory committees for child-welfare services have played an important part in stimulating interest and support for better laws affecting children. The varied and broad content of this legislation is illustrated by the following:

In ***Indiana*** the Welfare Act was amended in 1937 to make it possible to pay for foster care for certain children in need of it under circumstances not requiring that the child be made a public ward.

In ***Colorado*** a law was passed in 1939 authorizing the use of State administrative funds for 75 percent of the administrative costs of county welfare departments.

In ***Michigan*** a new adoption law was passed in 1944.

In ***Alaska*** a new Juvenile Code was adopted in 1943, abolishing the Board of Children's Guardians and transferring the custody of wards from this board to the public welfare department.

In ***Rhode Island*** in 1944 a juvenile-court act was passed, establishing an independent juvenile court with jurisdiction throughout the State over a broad range of subjects.

In ***Washington*** a law was passed in 1939 providing for the allocation of State and Federal funds for assistance on the basis of need in the respective counties as disclosed by quarterly budgets considered in conjunction with revenues. (This covers county costs for personnel and maintenance of children in foster care as well as in their own homes.)

In ***Virginia*** a law was passed in 1943, which provided for the licensing of foster homes, child-placing agencies, children's homes, and day nurseries.

A PERSPECTIVE

The provisions for child-welfare services under title V, part 3, of the Social Security Act reflected the interest and concern which had been growing over a period of years regarding the need for the development of public child-welfare services and for implementing and aiding this through Federal funds. This interest has increased and broadened in the decade just passed. Federal funds made available under title V, part 3, of the Social Security Act have provided a stimulus for unprecedented expansion in State and local services to children. The States have more and more been accepting responsibility for providing special services to children as an integral part of a broad public-welfare program. Every State public-welfare agency has developed new services to children or improved services already established. In every State the services of child-welfare workers have been put within reach of children and parents in local communities in at least some parts of the State.

Much progress has been made but much remains to be done. The services of child-welfare consultants of State public-welfare agencies are as yet available to only a small proportion of counties on a regular, continuing basis. Child-welfare workers are by no means fully available in all parts of every State. More funds — Federal, State, and local — are needed. More personnel and opportunities for training workers on the job are of utmost importance.

The first 10 years of child-welfare services under the Social Security Act have demonstrated the possibilities in better service to children through Federal, State, and local cooperation in providing for the special needs of children. The foundation has been laid for developing this cooperation to the extent necessary to assure that the responsibilities of the Government and of the Nation to its children are fulfilled.

BRITISH PLAN PEACETIME DAY CARE FOR CHILDREN

• In a circular addressed to local authorities the Minister of Health and the Minister of Education of England and Wales have made recommendations with regard to modification of existing arrangements for day care of young children.

This circular, dated December 14, 1945, states that the Ministers concerned accept the views of medical and other authority that, in the interest of the health and development of the child no less than for the benefit of the mother, the proper place for a child under 2 years of age is at home with his mother. They are also of the opinion, the circular says, that under normal peacetime conditions the right policy to pursue would be positively to discourage mothers of children under 2 from going out to work; to make provision for children between 2 and 5 by way of nursery schools and nursery classes; and to regard day nurseries and "daily guardians" as supplements to meet the special needs of children whose mothers must work on account of special circumstances, or whose homes are unsatisfactory from the health point of view, or whose mothers are unable to undertake the full care of their children.

The Ministers say that they recognize that this policy represents an ideal that cannot be attained immediately, that the period of transition from war to peace conditions is likely to be substantial, and that during that period in some areas the need for women workers may well be as urgent as it was during the war.

It had been expected that with the cessation of hostilities and the passing of the Education Act of 1944 nursery schools and nursery classes would take the place of the wartime nurseries.

It is believed, the circular says, that nursery schools and nursery classes will never wholly meet the need because they do not admit children under 2—or even under 3—and because they are open only during school time, and that some permanent provision may need to be made for the occasional care of children of all ages up to 5, in order that all mothers, whether or not they go out to work, may have reasonable opportunity for rest and relaxation apart from their homes and children.

Measurement of local need and the choice of the best methods of meeting it must rest primarily on the local authorities concerned, the circular goes on. Since some of the provisions to be made are within the province of the welfare authority, the planning of future arrangements must be undertaken jointly by the two authorities working in collaboration. The Ministers suggest a combination of the following methods:

1. Nursery schools, nursery classes, day nurseries, and plans for "daily guardians."

2. Use of maternity and child-welfare centers as temporary crèches two or three afternoons a week.

3. Organizing as volunteers responsible women or older girls willing to "sit in" at the homes of children while the parents go out together in the evening.

The local authorities are asked to consider which wartime nurseries should continue to be run under maternity and child-welfare powers; which should be taken over and run as nursery schools or nursery classes; and which should be closed. The costs of operating wartime nurseries and wartime nursery classes were to be borne by the Government until March 31. From that date such wartime nurseries as became nursery schools or nursery classes were to receive the normal education grant from the Ministry of Education. Wartime nurseries continuing as day nurseries are to receive a similar grant from the Minister of Health. This grant is also payable for registered "daily guardian" plans, afternoon crèches, and evening "sitters-in."

CHILDREN OF WORKING MOTHERS in Birmingham, England, are enjoying lunch at Flint Green Nursery. There is a nurse to every 5 children in the nursery.

Photograph by British Information Services

NEWS NOTES

Sending Toys and Educational Materials to Displaced Children in Europe

Toys and educational materials are needed by displaced children 2 to 7 years of age who are now in assembly centers in Europe. Many of these children have never seen a toy. Schools have been started by the displaced persons, but there is a great shortage of school supplies.

The United Nations Relief and Rehabilitation Administration is not permitted to buy these toys and educational materials for children, as its purchases must be confined to food, clothing, medicines, and such things. It will, however, provide transportation and delivery to the assembly centers.

The Association for Childhood Education, in its publication, "The Branch Exchange," November-December 1945, presents the following information for persons wishing to send toys and educational materials to children in the assembly centers:

Suggested contents

It is thought most practical to plan a package to serve 10 children for at least a month.

The suggestions for the contents of the boxes have been made by teachers of young children. Contents are not restricted to them, however, and you will think of many more things that can be included, but we urge that you observe the same care in selecting the toys and materials that you would for an individual child or a group of children of your own acquaintance. Choose sturdy toys that will withstand hard use. Be sure that they have no sharp edges and will not splinter easily, and that paints or other finishes are nonpoisonous.

Keep in mind the scarcity of materials of all kinds in Europe. If you send anything that must be put together after arrival, include whatever is necessary, such as nails, screws, needles, and thread.

Doll bed, unassembled (pieces cut to fit carton exactly).
Set of bedding to fit (mattress and pillowcase without filling, two sheets, bright-colored cover).
Doll—not less than 10 inches long.
Clothes to fit doll—several changes.
Set of plastic or metal dishes.
Lengths of cloth, pieces of oilcloth—bright colors.
Good picture books.
Large mounted pictures, simple and clear.
Blunt scissors—four pairs.
Crayons, assorted, hexagonal—six sets.
Newsprint, 12 by 18 inches; colored paper; mending paper.
Tubes of paste.
Paint brushes, long-handled—1-inch width.
Tempera paints, powdered.
Cord or string.
Wool, bright-colored—hanks or odds and ends.
Ball—leather or rubber if possible.
Transportation toys, nonwinding—cars, trucks, boats.
Puzzles, wooden.
Pounding boards.
Plasticine or powdered clay.
Tongue depressors.
Paper clips.
Safetypins.
Sand toys—pans, spoons, sieves.

Packing

Some uniformity must be maintained in the size and weight of cartons so that they may be carried with reasonable ease by one person.

Weight should not be over 25 pounds.

Size should be approximately 12 by 17 by 9 inches. Cartons that meet requirements can be secured from grocery stores, such as cartons that have contained 25 2-pound packages of flour, or 48 large-sized cans of evaporated milk, or 12 No. 5 cans of tomato juice.

Shipping

Each carton should bear your return address and be plainly marked:

Kit of toys for children 2 to 7 years old, in assembly centers of displaced persons.

Enclose a sheet 8½ by 11 inches, set up as follows:

To the person opening this package:
Please return this sheet at once to:
Association for Childhood Education,
1201 Sixteenth Street NW., Washington 6, D. C., U. S. A.

1. A package of children's toys was received ______________ (date)
2. From ______________ (name of sender)
3. Materials were in good ☐ poor ☐ condition.
4. Please comment on how they are being used: ______________________________

(Signature and full address of person filling in form.)

This information is needed for future planning. If group or individual sending package wishes information concerning its receipt a second sheet may be enclosed.

Ship prepaid to:

UNRRA Consolidated Warehouse No. 3,
43 Clarkson Street, New York, N. Y.

Then notify:

UNRRA—Attention of Mr. H. F. Lofgren,
Ocean Shipping Division,
111 Broadway, New York, N. Y.

Give Mr. Lofgren this information:

Number of cartons.
Date of shipment.
How sent—prepaid express or freight, or parcel post.

Send a postcard to Association for Childhood Education, telling how many cartons were shipped and when.

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Executive Committee Appointed for New National Commission on Children and Youth

On nomination by a committee appointed by the chairman of the National Commission on Children in Wartime, which held its final meeting February 5 to 7, 1946, the Chief of the Children's Bureau has appointed an executive committee for a new National Commission on Children and Youth.

The executive committee met March 11 and elected officers for the commission; these officers also became members of the executive committee.

Appointments to the commission are now under consideration.

The names of the officers and members of the executive committee are as follows:

Chairman, Leonard W. Mayo, Cleveland, Ohio.
First vice chairman, George S. Stevenson, M. D., New York, N. Y.
Second vice chairman, Boris Shishkin, Washington, D. C.
Third vice chairman, Pearl A. Wanamaker, Olympia, Wash.
Secretary, Mrs. Wm. W. M. Henry, Dover, Del.
Kermit Eby, Washington, D. C.
Frank P. Graham, Chapel Hill, N. C.
Henry F. Helmholz, M. D., Rochester, Minn.
Mrs. Harriet A. Houdlette, Washington, D. C.
Hon. Anna M. Kross, New York, N. Y.
Mary E. Leeper, Washington, D. C.
Carl N. Neupert, M. D., Madison, Wis.
W. S. Terry, Jr., Baton Rouge, La.
H. Councill Trenholm, Montgomery, Ala.
Mrs. Roy C. F. Weagly, Hagerstown, Md.
C.-E. A. Winslew, D. P. H., New Haven, Conn.
Mrs. Gertrude Folks Zimand, New York, N. Y.

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Fourth Annual Meeting of United States-Mexico Border Health Association

Maternal and child health and welfare will have an important place on the agenda of the fourth annual meeting of the United States-Mexico Border Public Health Association, to be held in El Paso, Tex., and Juarez, Mexico, April 29–30 and May 1. The subject was included in the program of the association for the first time in 1945, and as a result of recommendations made at that time, special committees were appointed by Mexico and the United States to develop cooperation between the two countries in dealing with problems of maternal and child health and welfare in the border States.

A meeting of the two committees, held last November in Laredo, Tex., and followed by visits to health agencies on the Mexican side of the border reviewed in a preliminary way various problems and made recommendations for the program of the association's meeting.

The members of the Mexican committee are: Dr. Armando G. Herrera, Chihuahua; Dr. Alfonso Gaytán Alcántara, Mexicali; Dr. Jorge Burgette Rovira, Reynosa; and Dr. Arturo González Avila, Mexico City (liaison between the Division of Child Health and Welfare of the Mexican Department of Public Health and Public Assistance and the Mexican committee).

The members of the United States committee are: Ann M. Bracken, Phoenix, Ariz.; Dr. Hilda H. Kroeger, Phoenix, Ariz.; Howard L. Lackey, Austin, Tex.; Dr. Lewis Robbins, San Antonio, Tex.; and Elisabeth Shirley Enochs, Washington, D. C. (liaison between the Children's Bureau and the United States committee).

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Planning for Children and Youth in Kentucky

The Kentucky Youth Guidance Commission, on December 1, 1945, issued a report based on 612 returns from county chairmen appointed by the commission; county and circuit judges; county, city, and parochial-school superintendents; and civic leaders. The commission includes a member from each of the nine Congressional districts in the State, with Joshua B. Everett serving as chairman. The report was compiled by the executive secretary, W. E. Watson, Mental Hygiene Division, State Department of Welfare.

Among the conclusions of the report are that any trend toward an increase in juvenile delinquency related to legal procedure results more from defective enforcemen of law than from lack of statutory provision, and that "the enormous increase in juvenile delinquency in Kentucky" has been inexcusably publicized and exaggerated.

The commission's recommendations point out a number of the State's needs. Among those listed are the following:

Thorough study of juvenile-court procedure in the State.

A juvenile-detention home, or supervised detention foster care, in every county.

A child-welfare unit, under the supervision of the child-welfare division of the State department of welfare, in every county.

Recodification and simplification of juvenile laws.

Expansion of State-wide mental-hygiene services to include psychologic, and when possible psychiatric, services to the schools.

Provision in the public schools for training mental defectives.

Programs of physical and mental health in the public schools.

Training for teachers in mental hygiene.

A course in character education in all schools.

A State-wide recreation program.

Collection of data to aid communities in operating recreation programs, including youth centers.

Edith Rockwood.

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For Your Bookshelf

CHILDHOOD MORTALITY FROM ACCIDENTS. BY AGE, RACE AND SEX, AND BY TYPE OF ACCIDENT, by George Wolff, M. D. Publication No. 311. U. S. Department of Labor, Children's Bureau, Washington, 1945, 25 pp.

Almost 20,000 boys and girls in the United States die from accidents each year, says this bulletin, and there is no doubt that the great majority of these deaths could be prevented. As a step toward reduction of this wastage of child life, the Children's Bureau has published this study of death rates for specified types of accidents among children and adolescents, based on data from the Bureau of the Census for the years 1939, 1940, and 1941.

A limited number of copies is available for distribution.

U. S. GOVERNMENT PRINTING OFFICE: 1946

VOL. 10—NO. 11
MAY 1946

The CHILD

CHILDREN'S BUREAU • U. S. DEPARTMENT OF LABOR

- SQUARE DEAL FOR BABY BORN OUT OF WEDLOCK
- NEW BRITISH EDUCATION LAW
- EMOTIONAL PROBLEMS OF CRIPPLED ADOLESCENTS

U. S. SUPERINTENDENT OF DOCUMENTS
JUL 25 1946

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The CHILD

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The picture on the cover is a Library of Congress photograph.

The drawing on page 167 is by Constance Dillon.

U. S. DEPARTMENT OF LABOR
L. B. Schwellenbach, *Secretary*

CHILDREN'S BUREAU
Katharine F. Lenroot, *Chief*

CHILD HEALTH DAY, 1946

Never before in our history has so much attention been focused on the Nation's health. President Truman has called for a National Health Program. Congressional committees are considering bills to implement the President's program: to provide Federal aid to the States for dental and mental health services and for maternal and child health; to finance research in cancer, in dental diseases, in mental health, in poliomyelitis; to build hospitals and clinics.

Against this background of public concern comes Child Health Day, 1946, with the President's challenging proclamation urging the "people in each of our communities" to pledge themselves on May 1 to review their community health and medical-care services (1) "to see how well these services meet the needs of all our children in the light of the goals of the National Health Program", and (2) "to organize a definite plan to achieve within the coming year at least one improvement in community health services which will contribute to the better health of children."

The President reminds us that "the health of American children, like their education, should be recognized as a definite public responsibility," and a responsibility of each community as well as of the Nation.

Concretely, what can a community do "to achieve within the coming year at least one improvement" in health services for children? That depends on what there is to build on.

Your health agency, for instance. Is it well staffed and financed? How about hospital facilities? Are there out-patient or other clinics for mothers and children?

How do your maternal and infant death rates compare with those of other communities? How many maternity clinics are held regularly? Are the mothers who attend these clinics assured continuous medical and nursing care through pregnancy, delivery, and the postpartum period? Are there enough public-health nurses for prenatal and postnatal home visits? How many births occurred last year without a doctor? If midwives may practice, does your health agency supervise them?

How many child-health conferences are there conducted by a doctor? Are there enough public-health nurses for home visits? How many infants and preschool children are under such supervision? How many preschool children are immunized against diphtheria, smallpox, and other communicable diseases? What dental care is provided for preschool children?

Does your school health program provide regular examinations by doctors and dentists, and follow-up care? Does this program include correction of defects found at examination? How many children have defects corrected? Do your schools have health-education programs? Are school lunches provided at cost, or free? Does your health department guard the health of boys and girls who leave school for work?

What is done to find crippled children and give them care? Is there a community program for children with rheumatic heart disease?

Has your community a program for parent education in mental health? A child-guidance clinic, with a psychiatrist, a psychologist, and social workers?

From these questions some ideas for "at least one improvement" in community health services for children may arise. Talk them over with your health officer.

Martha M. Eliot

Martha M. Eliot, M. D.,
Associate Chief, Children's Bureau.

Publication of The Child, Monthly Bulletin, with Social Statistics supplements from time to time, was authorized by the Bureau of the Budget, May 12, 1936, under Rule 42 of the Joint Committee on Printing, to meet the needs of agencies working with or for children for a regular channel of information on current developments, activities, policies, and programs for maintaining the health of mothers and children, providing child-welfare services, and safeguarding the employment of youth. Address The Child, Children's Bureau, U. S. Department of Labor, Washington 25, D. C. The Children's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. The Child is for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at $1 a year; foreign postage, 25 cents additional; single copies, 10 cents.

WANTED: A SQUARE DEAL FOR THE BABY BORN OUT OF WEDLOCK

"Our Concern Every Child" should apply to child of illegitimate birth

by *MAUD MORLOCK*, *Consultant in Services for Unmarried Mothers Social Service Division, U. S. Children's Bureau*

• A baby born out of wedlock usually comes into the world unplanned for and often unwanted. He is deprived of normal family life, with both a father and a mother to give him love and security, as well as physical necessities.

His mother may not be equal to the task of planning for his welfare. (About half such mothers are under 20 when the baby is born.) The mother herself may feel unloved and unwanted. Though today the attitudes of society toward unmarried mothers are improving, the attitudes of some individual parents still need to change. Unfortunately some parents do not give their daughter sympathetic support in this emergency. They may even turn her out of the home.

The majority of unmarried mothers need the skilled help of a social worker. The sooner the mother receives such help, the more satisfactory is the protection given the baby. She especially needs this help in making her decision whether to keep the baby or give him up for adoption. Many of these babies are kept by their mothers, but it frequently takes a stout heart to face family, friends, and community with a child whose circumstances of birth are disapproved by society.

And it isn't just facing the world for a few months. Long years are ahead when both mother and child will have to face this issue again and again. Schoolmates may ask the child about his father; a birth certificate may have to be shown; the child himself may ask his mother where his father is.

Then, suppose the mother eventually marries some one other than the father of the child. Will the child be fully accepted in the home or will he be an unhappy reminder of misfortune?

If the mother keeps the custody of her child but cannot keep him with her where she is living, or with relatives or friends, she will probably have to board him in foster care, either in a family home or in an institution.

And money will be needed to support the child. Many a mother cannot earn enough for this, and unless relatives help she will need financial assistance. Public and private social agencies often provide this. In many States "aid to dependent children" is one resource; in some, such provision is available even for an unborn child.

Besides a child's physical needs, which money can usually take care of, there are his other needs—his need for normal family life, for affection, for mothering.

Consider the baby born out of wedlock who is taken directly to an institution from the hospital where he was born and who may remain in the institution several years. Such a baby obviously cannot get the individual mothering he needs.

Another baby is placed by his mother in a foster home, but she has little affection for him, visits him only irregularly, and assumes little responsibility for his welfare. Another is visited often by his mother, but she is so critical of the foster mother that the baby must be moved from one home to another. The behavior of either of these mothers may show that she doesn't really want to keep the child, yet she has never been able to arrive at a decision to give him up for adoption.

Perhaps the mother decides to give up her baby. At present, when people are clamoring for babies and will go to almost any extreme to obtain one for adoption, the baby of illegitimate birth especially needs the law's protection from the hazards of an undesirable home.

Some State laws try to protect the baby by refusing to recognize as legal any relinquishment of parental rights without court sanction. In one State a relinquishment by an unmarried mother is voidable at any time within 120 days after it is signed.

Still more protection would be given to the baby if the State welfare department, or its designated agency, were required to do what it does in case of an adoption petition; that is, to study the situation, know the parents, and report to the court that is to pass upon the relinquishment.

If the law contains a provision enabling the unmarried mother to relinquish her child to a social agency, special protection is given to the child, as well as to his mother and to any couple that may adopt him, as the social agency then has the power to consent to adoption without the identity of either the natural parents or the adopting parents being revealed to the other.

In some States the child is practically unprotected by the law, for the mother may give up her parental rights merely by informally signing a paper. Thus she gives her child away without knowing what is to become of him, except that the person who takes the child has agreed to place him. Some of the dangers of this kind of placement were discussed in *The Child* for January 1946.

A mother who relinquishes her rights to a child usually does so expecting that he will be adopted, and it is vitally important that the child be placed in a suitable home. It has been reported from many States that courts are reluctant to remove a child from a home once placement has been made, except for gross neglect.

A difficult situation

One situation that is not new but is causing great perplexity at present involves the child born to a married woman, whose husband is not the father. Usually the husband is or has been in military service.

The current attitude of society is to blame the married woman who gives birth to a child out of wedlock even more severely than the unmarried one. She is pictured as the unfaithful wife who was having a good time while the husband was facing death in a foxhole. Public understanding and concern for wives of soldiers do not carry over to the wife who becomes illegitimately pregnant. Many wives have had to assume responsibility for the home and children, for which they were poorly prepared. The loneliness in some instances has been almost unbearable, and their need for a man's emotional support and sometimes for financial help has led them into extramarital involvements.

In ordinary times courts hearing divorce cases do not usually remove custody of the children from the mother unless there is gross neglect or incompetency. Reports now indicate, however, that some mothers are losing custody of their legitimate children. Sometimes the interests of the child are overlooked.

The principal actors in the drama are of course the wife and the husband. Their marriage may have been stable, or it may have been based on a superficial relationship. The real father of the baby may still be at hand, with affection existing between him and the mother, or he may be absent, in body and spirit.

Almost more than she can bear

It is no wonder that when the wife finds she is pregnant by a man not her husband she feels that she has lost everything—her husband, home, legitimate children, friends, and reputation, as well as income. Her anxiety, guilt, and remorse may be almost greater than she can bear.

Some women resort to abortion as the easiest way out.

Others tell their husbands the truth, with varying results. Some men may be willing to forget the past, and accept the child. However, to many other men the presence of a child born out of wedlock during his absence is a constant reminder of the wife's infidelity.

Some mothers try to place the baby immediately for adoption without notifying the husband. Such a mother usually wants immediate action, as in her mind delay may lead to discovery. If she is blocked in her plan by laws or interpretations of the laws, she is likely to give her child to anyone who will take it.

A few instances have been reported in which the husband on his return home has instituted court procedure to regain a child already placed in an adoptive home.

Reports of court cases indicate that sometimes, when the husband returns, a divorce decree is granted within a few weeks. In some instances judges have at least threatened action for adultery.

No legal complications arise when the mother confides in her husband and he is willing to accept the child; nor if they both want to relinquish their parental rights and place the child for adoption.

But whether the mother can place the child for adoption without notifying her husband depends on what State she lives in. In some States it is possible for her to go into court and by independent legal action establish that her child is not the child of her husband. In other States the child cannot be adopted without the husband's knowledge and consent.

This difficult situation needs a skillful, objective, and mature social worker. She should share her responsibility for treatment and planning with a well-qualified supervisor. Competent legal advice should be available.

If the mother's plan of giving up the baby without her husband's consent cannot be followed or if it is agreed that it is not a wise plan, an alternative plan should be made that is in keeping with the mother's wishes insofar as this is possible.

Many persons born out of wedlock have been humiliated by having to show a document that shows illegitimate birth. People have learned of their illegitimate birth for the first time when obtaining a birth certificate. Men in the armed services have refused promotion because they did not want their commanding officer to know of their illegitimate birth. Children entering school and young persons seeking work have had to show birth certificates bearing the word "illegitimate."

Use of birth cards

Some States are trying to remedy this through the use of birth cards instead of birth certificates. These cards, based upon the certificates, have on them only the essential identification — legal name, and place and date of birth.

In some States, a new birth certificate for an adopted child is issued in the adoptive name; the original is then sealed and held confidential.

Every effort should be made to

have the original birth certificate accurate, and to preserve it, for every person has a right to know who he is and who his people were. Basic, of course, to good birth registration is the principle that birth records should be confidential documents, not open to inspection by the general public nor available for commercial purposes.

If babies born out of wedlock are to have their interests safeguarded every community must set its house in order in regard to services to unmarried mothers. Services that reach only few mothers and few babies, regardless of how excellent those services are, do not constitute a good community program. It is futile to wring our hands over independent placements and at the same time raise barriers to placement that would safeguard the child.

Some of the barriers that keep babies from being placed by an authorized agency are the policies of these very agencies, such as unwillingness to accept nonresidents.

Practices may confuse mother

Having a girl go from one agency to another and repeat her story is another besetting sin of agencies. Coupled with this are innumerable delays—from the postponement of the first interview with the mother for several weeks and slight contact with her during pregnancy, to postponement of the placement of the child.

With such confusion existing in our practices, is it any wonder that members of other professions take the matter into their own hands and place for adoption babies born out of wedlock?

It is true that one can mobilize reasons for the shortcomings of agencies. They include shortage of funds, staff inadequate in number and training, and lack of agreements between agencies as to what each should do. They are all serious obstacles to good service.

Concern shown by communities

Fortunately, more and more communities are doing something about this situation. Their concern is manifested through such activities as the following:

1. Committees are working in many places. They are striving for better State and community planning, and for laws that will give better protection to all the parties concerned in regard to relinquishment, adoption, licensing of child-placing agencies, and birth registration.

Photograph by Arthur C. Allen. Lent by United Charities of Chicago

THIS BABY is getting a square deal. His mother consulted a social agency early in her pregnancy. Now, with the skilled guidance and sympathetic help of her social worker, she is making plans for the future of her baby and herself.

2. Pamphlets are being issued explaining to unmarried mothers, physicians, and others what good social service to unmarried mothers is and where it is available. Such material has been prepared jointly by representatives of social agencies, medical and bar associations, and others, and has been sent out to members of these professional groups. Material issued by the Children's Bureau has also been distributed.

3. Funds are available through some State departments of welfare to provide care for the unmarried mother and her baby if she does not want her situation known in her own community.

4. A real effort to provide immediate boarding care for infants is being made.

5. Agencies are striving for staffs that are well-qualified and are in sufficient number to provide service for any unmarried mother who needs assistance. Child-welfare workers are being employed in increasing numbers in rural areas, where they will be easily accessible when needed. •

Condensed from paper given November 28, 1945, at the forty-first annual meeting of the Massachusetts Conference of Social Work, Boston.

Reprints available on request.

RECENT C. B. PUBLICATION

MATERNITY HOMES FOR UNMARRIED MOTHERS; a community service, by Maud Morlock and Hilary Campbell. Pub. 309. U. S. Department of Labor, Children's Bureau, Washington, 1946. 94 pp.

Written for the inner circle of board and staff, this bulletin will be useful to a wider group. It covers case-work, group-work, and health and medical services for mothers and babies in a maternity home.

Single copies are free upon request to the Children's Bureau.

NEW EDUCATION LAW IN GREAT BRITAIN LOOKS TO THE FUTURE

by *ELLA ARVILLA MERRITT*, ***Specialist in Child-Labor Research Industrial Division, U. S. Children's Bureau***

• Opening the United Nations Educational Conference, which convened in London last November and established the United Nations Educational, Scientific, and Cultural Organization, Prime Minister Attlee said:

"The field of educational and cultural relationships is surely one of the richest and most significant in the international life of the world. * * * All of us hope to educate our people *for the world we want to build.*" (Italics by editor.)

Great Britain took the first step toward enlarging the scope of its program for broader education, when in 1944, after long governmental planning and public discussion, Parliament enacted the "Education Bill," designated "a bill to reform the law relating to education in England and Wales."[1]

This bill, which was the first of the Government's major measures of social reconstruction, became a law August 3, 1944, 9 months before V–E day. It supersedes all prior acts and in particular repeals the Education Act of 1936, which was to have gone into operation September 1, 1939, but which was suspended because of the war emergency. When it becomes fully operative, it will provide for free public education for all children up to the age of 18.

Already certain provisions changing and simplifying the general structure of education have come into force. Especially significant is the change that has been made in the classification of publicly aided education, which formerly fell into two main divisions; that is, a system of public elementary schools covering the age of compulsory school attendance (from 5 to 14 years of age) and a system of "higher education." This was replaced on April 1, 1945, by a new classification, with three main divisions. In the words of section 7 of the act:

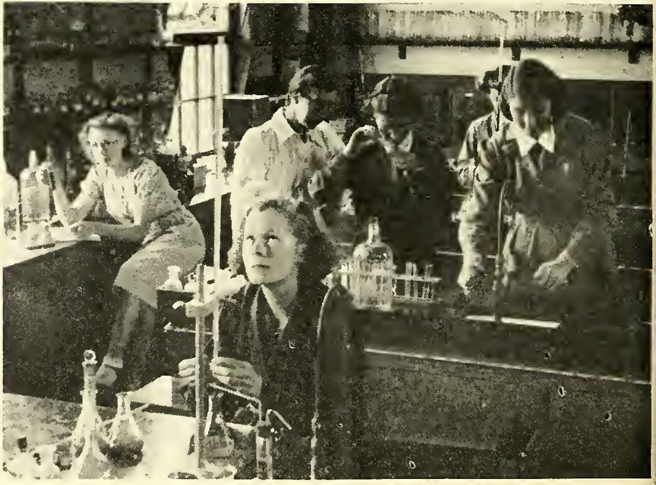
"The statutory system of public education shall be organized in three progressive stages, to be known as primary education, secondary education, and further education; and it shall be the duty of the local education authority for every area, so far as their powers extend, to contribute towards the spiritual, moral, mental, and physical development of the community by securing that efficient education throughout those stages shall be available to meet the needs of the population of their area."

Thus for the first time the educational process is regarded as a continuous one, through which all children and young people will pass, and all children will be given a full-time secondary education.

"Primary education" covers all educational provision for children between the ages of 5 and 11. In this area the act urges the need for reduction in the size of classes to a maximum of 40 children, and fewer wherever possible. The "secondary schools" are for children from 11 to 14 years (and older children after the upper age limit for compulsory education is raised) and are divided into three main types with the object of ensuring that every child shall receive the kind of education best

YOUNG PEOPLE OF THIS AGE in England are not yet required by law to go to school. But the new education act will eventually require attendance, full-time or part-time, of all boys and girls until they are 18 years of age.

British Official Photograph



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[1] A bill for Scotland which would make changes in the age for compulsory school attendance and in provision for part-time school attendance to 18 years of age, corresponding to those now in the Education Law for England and Wales, was introduced in Parliament in 1944, but has not advanced beyond the bill stage.

suited to his abilities and aptitudes.

The provisions of the law for compulsory attendance of all children in primary and secondary schools in effect fix a minimum age for employment of children during school hours. At present full-time education is required up to 14 years, and children are permitted to leave school for work at 14. On April 1, 1947, the age for the completion of compulsory education (and therefore the minimum age for employment during school hours) will be raised to 15 years, and subsequently, when the Minister of Education is satisfied that sufficient buildings and teachers are available, to 16 years.

Further education

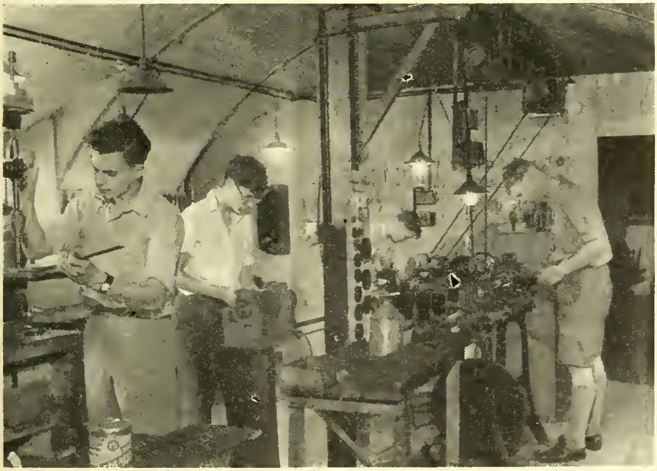
After boys and girls have passed the age for full-time compulsory attendance, they will be required to attend "county colleges" at least to the age of 18 unless they are attending school full time. This attendance falls in the class of "further education." County colleges will be established, in due course, for all young people who have left school before reaching the age of 18. If the young person is employed, the required part-time attendance must be during working hours. It may be for 1 whole day, or 2 half days, in each of 44 weeks in each year, or for one continuous period of 8 weeks in each year, or for two continuous 4-week periods in each year.

In planning for this compulsory part-time attendance, which normally will be 1 day a week, the Ministry of Education says:

"It is felt that no wage-earning occupation, however skillful or absorbing (and there are many which are neither) can by itself be a proper education for those who have left school at 15; that young people need to be kept in touch with the life, the discipline, the teaching, and the outlook of an educational institution for some years after they have become wage earners, and that their personal happiness will be increased and their lives made richer by such a contact. On the other hand, experience has shown that the well-trained and educated make the best workers; that those who maintain contact with organized education make, on the whole, the most responsible citizens, and that complete withdrawal from education at 14 has led to much of the effort of the elementary school being wasted."

VOCATIONAL EDUCATION, both part-time and full-time, with more adequate and better-coordinated facilities than those available at present, will be provided in England's school system when the new education act goes into full effect.

British Official Photograph



In addition to establishing these provisions for compulsory education, the law requires local education authorities to establish nursery schools whenever there is a reasonable demand. Children are permitted to attend these schools from the age of 2 or 3 years to 5 years, the age at which compulsory school attendance begins.

To submit comprehensive plan

At the other end of the scale, much wider provision than at present is made for extension of adult education. Local education authorities, which have the duty of providing adequate facilities for such education, are to consult universities and educational associations, and also other local education authorities, and submit comprehensive plans to the Minister; and the Minister will direct the local authority in putting the plans into effect.

"Further education" will also include provision of more adequate and better coordinated facilities for part-time and full-time vocational training both for young people and adults, and expanded provisions for nonvocational education and for recreational activities.

Financial help to pupils

In order that the education of youth shall be extended as widely as possible, no fees are to be charged in either primary or secondary schools (formerly prohibition of fee charging applied to primary schools only), and local authorities are to be empowered, under regulations made by the Minister, to give financial assistance to pupils, to enable them to take advantage of educational facilities available to them without hardship to themselves or their parents. This aid may cover expenses needed for taking part in school activities, and, under certain conditions, board, lodging, and suitable clothing. Local authorities are also to be required to make provision for free milk and meals. Free medical examinations and opportunity for free medical treatment for all children attending primary or secondary schools must also be provided. This last provision went into effect April 1, 1945, and will remain in the hands of local authorities until it is integrated with the National Health Service, which was proposed in Parliament in March 1946.

Equal access to education

Certain important changes have been made in the general educational structure. The President of the Board of Education is now called the Minister of Education, and for the first time this official is given effective power to secure development of a national policy in education. Under the 1921 Education Act the Board had superintendence merely of matters relating to education. Under the 1944 Act the Minister has the duty of "promoting the education of the people * * * and the progressive development of institutions devoted to that purpose, and of securing the effective execution, by local education authorities under his control and direction, of the national policy in providing a varied and comprehensive educational service in every area." This change, while continuing to allow wide scope for local initiative, aims to give every child, wherever he lives, equal access to the benefits of the new education.

Minister of Education a woman

Two Central Advisory Councils, one for England and one for Wales, have been established to advise the Minister concerning educational theory and practice. Unlike the Consultative Committee, which they replace, they are not confined to consideration of matters referred to them, but can take the initiative in introducing questions of policy.

When the Labor Government came into office in July 1945, Miss Ellen Wilkinson became Minister of Education and Britain's only woman member of the Cabinet. She was elected to Parliament in 1924 as member for a large industrial constituency, and, with the exception of one short break, has served as a Labor Member of Parliament ever since.

Cooperation With the Philippines

At the request of the Government of the Commonwealth of the Philippines, two representatives of the Children's Bureau recently flew to Manila to cooperate in a broad survey of conditions relating to maternal and child health and welfare as a basis for planning the development of permanent services under the new Government of the islands, which, after July 4, will assume their place among the independent nations of the world.

Samuel M. Wishik, M. D., former Director of the Bureau of Maternal and Child Health, Territorial Board of Health of Hawaii, and Herbert E. Chamberlain, M. D., Consulting Psychiatrist, Division of Child Welfare Services, State Department of Social Welfare of California, joined the staff of the Children's Bureau on May 15 for assignment to the Philippines for a 3-month period, during which they will study problems created by the war and enemy occupation and the resources needed to develop services for mothers and children.

The request for the cooperation of the Children's Bureau was made on behalf of the Philippines by Brig. Gen. Carlos P. Romulo, Resident Commissioner of the Philippines in Washington. In a letter forwarded to the Secretary of Labor through the Secretary of Interior, General Romulo referred to the extensive reconstruction program to be carried out under the terms of the Philippine Rehabilitation Act of 1946 (Public Law 370, 79th Cong.) and suggested that the first step in planning for the organization of permanent health and welfare services for mothers and children should be "the collection of data, statistics, and all information that would form the basis of any planning." This, he indicated, could best be accomplished by sending a small group of specialists from the Children's Bureau to the islands to obtain first-hand knowledge of conditions, later bringing to the United States key members of maternal and child health and welfare agencies of the Philippine Government to study the latest developments in these fields in this country.

Although the Children's Bureau was aware of the urgency of the need and in fullest sympathy with the request made by General Romulo, it had no funds that could be used to give the desired service. Consequently the Secretary of Labor referred the request to the Department of State, with the result that funds available for cooperation with the Philippines were transferred to the Department of Labor by the Department of State, through its Office of International Information and Cultural Affairs.

While negotiations between the two Departments were being carried on with a view to financing the project, the details of cooperation were being worked out by the Chief of the Children's Bureau and representatives of the Philippine Government, particularly Arturo B. Rotor, M. D., Technical Assistant to the President of the Philippines, and with the cooperation of the Far Eastern Area Division of the Office of International Information and Cultural Affairs of the Department of State.

General Romulo wrote to the Hon. Vicente G. Sinco, Commissioner of Foreign Relations of the Philippines concerning the assignment of the two specialists from the Children's Bureau, requesting assistance in working out plans for their cooperation with the proper officials of the Department of Public Health and Welfare, the College of Medicine, the University of the Philippines, and other appropriate agencies and officials.

After completing the necessary preparations, Dr. Wishik and Dr. Chamberlain took off for Manila.

In the course of their challenging assignment the two representatives of the Children's Bureau will have the rare experience of witnessing the birth of a Nation when the Philippines achieve their full independence on July 4.

Elisabeth Shirley Enochs.

SOCIAL WORKER HELPS HANDICAPPED ADOLESCENTS WITH EMOTIONAL PROBLEMS

Acts as part of medical team to treat "whole child"

by *EDNA M. LAMPRON*

Psychiatric Social Worker
Detroit Orthopaedic Clinic

• An adolescent who must go to the hospital for orthopedic treatment is likely to resent it, unlike a young child, who is likely to take it as a matter of course. The adolescent may resent not only the hospitalization but the necessity for leaving his home, being separated from his family and friends, and interrupting his school life and other activities.

For many orthopedic conditions the surgery does not consist of a single operation, but a series of them, and the young patient has to remain under the supervision of the surgeon for years, sometimes until he is grown up. Each time a new procedure is begun, the child's earlier experiences tend to re-create themselves and to intensify the more recent ones.

Also, when an adolescent must make adjustments again and again, as he goes to the hospital, then to the convalescent home, back to his own home, and then again to the hospital, he must accept these difficulties while going through the normal conflicts of adolescence.

A crippled adolescent, like other adolescents, is attempting to relate himself to his world and is struggling with the process of growing up. Like other adolescents, he does much self-questioning. He becomes aware that he is different from most young people, and he realizes that his world and his activities are extremely limited. If he is disfigured, or is unable to use a leg or an arm or some other part of the body, he may be unable to achieve satisfactory adjustment to the boy-and-girl world. He resents his limitations and needs help in accepting them. But if he learns to accept them he may eventually function successfully within his capacity.

The crippled young person can achieve this success more easily if he has the advantage of a corrective plan to help meet not only his orthopedic needs, but also his emotional ones. Resources for the general rehabilitation of a handicapped young person can be coordinated successfully through cooperation by the doctor, the nurse, the physical therapist, the social worker, the occupational therapist, the teacher in the special school, and the workers in the sheltered workshop and the rehabilitation bureau.

Medical team responsible

If the handicapped adolescent is to achieve a mature, well-adjusted personality and to attain the maximum degree of rehabilitation possible for him, personality difficulties should be recognized early and remedial measures begun. This early recognition and treatment are the responsibility of the medical team—the doctor, the nurse, and the medical-social worker.

To give some idea of the help that social workers are able to give handicapped children as they grow into adolescence, this paper presents the results of a study of 5 years' medical and social records of a number of boys and girls under care at the Detroit Orthopaedic Clinic. The clinic for the past quarter century has been providing medical services to orthopedically handicapped children and young adults.

About 10 years ago the clinic expanded its program, supplementing its medical services with general services that emphasize the whole child. The additional services include guidance in personality adjustment, provision of recreational opportunities, social case-work service, group therapy, clubs, and education—a hospital convalescent school and a nursery school.

The children whose records were selected for study all had handicaps that made them noticeably different from other children. (Children with handicaps due to cerebral palsy were not included, as these children's social development is much more difficult to evaluate than that of other handicapped children.)

When the 34 boys and 26 girls in the group entered the clinic their ages ranged from 9 to 17 years.

Twenty-four were of American parentage, and 36 were American-born children of foreign parentage.

Thirty-one were Protestants; 29 were Roman Catholics.

Thirty had both parents in the home; the other 30 came from broken homes.

Twenty-seven of the families had incomes that were adequate for the family needs, but insufficient to pay for orthopedic care. Thirteen were totally dependent on public assistance for family needs; 20 were partly dependent.

Poliomyelitis was the most common diagnosis for these children. Thirty-two had had this diagnosis; the diagnoses for the other 28 fell into 17 different orthopedic classifications, the more common being scoliosis (7), osteomyelitis (4), and spina bifida (3).

Thirty-two of the children had had little play activity in their early years, as they had been handicapped before they were 5 years of age. Perhaps these children made a more comfortable adjustment to their handicaps, because unlike the other 28, they had never known full physical activity.

Fifty of the children had had orthopedic surgery; 39 of these had had from 2 to 9 operations, and had spent from a month to 3 years in a hospital. Most of the group had had, in addition, long periods of physical therapy. Also they had had casts applied, or had worn braces or special shoes, or had used crutches. Forty-three had attended an orthopedic school at some time.

Some of the children were retarded in their school grades. Some high-school pupils were 1 or 2 years behind, largely as a result of having been out of school for treatment.

Mental endowment studied

Psychometric examinations were obtained in many cases in which there was a question as to the child's mental endowment and such an examination was needed for vocational planning. Only two children received psychiatric study, as the clinic did not have this service at that time, and the community facilities were limited.

The clinic workers realized that little recreation was available for the boys and girls and that they needed to have some group experience before they would be ready to participate in ordinary group activities. With this in view the clinic initiated boys' and girls' clubs. The leaders were experienced in group work and used opportunities for the patient's release of energies and feelings. Written observations by the leaders helped the social worker to evaluate each patient's reaction to his handicap, and the degree to which he adjusted himself to group experience. Later, the boys and girls 16 years of age or over were helped to organize clubs through which they had opportunities for satisfactory boy-and-girl relationships and participation in community activities.

The social worker arranged for school or camp placement for some boys and girls and helped some to make vocational plans.

Freedom to express feelings

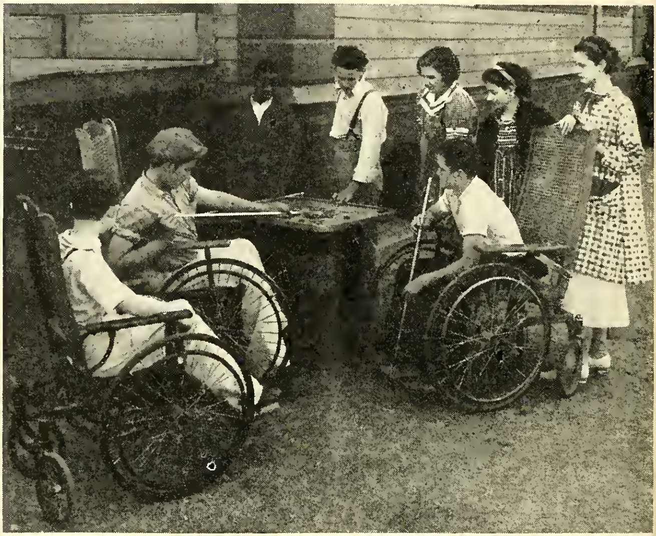
The worker's efforts were directed toward knowing the child and his family and gaining their confidence so that they felt free to express their feelings. When the parents were unable to accept guidance, the social worker focused the treatment on the adolescent himself, as in the case of Eddie.

Eddie came to the attention of the clinic at the age of 13, in need of corrective surgery. His arm and leg were paralyzed as a result of poliomyelitis contracted at the age of 6 months. He was bitter about his handicap, and after the surgery refused to try many activities that the doctor felt he was able to do. He refused to associate with boys and girls of his own age, was failing in his school work in spite of superior intelligence, and had threatened suicide.

The story does not begin with Eddie at 13, but in infancy, when his father played with him and exercised his tiny arms and legs, and hoped to make an athlete of him. These dreams were abruptly shattered when Eddie was stricken with infantile paralysis. Heartbroken, the father could see only the remnants of a plan that could never be realized, and gradually he turned away from the boy, giving all his attention to a second child, a husky, athletic girl. The bewildered mother pampered her son, but was not mature enough to understand how to help him effectively.

The handicap of Eddie's point of view could not be remedied by medical and surgical procedures alone. Here was a boy very much in need of "plus" service, which the clinic had to offer. Simultaneously with the doctor's treatment, the social worker began a series of conferences with Eddie, which lasted more than 2 years. He began to know and trust her as a friendly, sympathetic person. He could tell her of his unhappiness about his home. In a way she became a parent to him, and at the same time she was working with his parents to help them understand Eddie and what his crippled condition meant to him.

As soon as Eddie began to feel surer of himself at home, more certain that his family really loved him in spite of his physical disability, the social worker persuad-



Photograph lent by U. S. Office of Education

RECREATION TIME in a school for crippled children. Playing with other children of their own age helps adolescents to conquer the self-consciousness many feel.

ed and helped him to make his first steps toward getting along with other boys his own age. This was accomplished through the clinic boys' club, where he learned to share with others. In spite of a useless right arm, he became expert at ping-pong, and before long was independently associating with boys in his neighborhood.

Eddie began to need money to keep up with his new friends, but he was afraid to ride on street cars or go about the streets alone. However, when a job in a small candy store was offered him it meant so much to him that he overcame his dread of riding street cars. When he wished to change his work a second job was found for him. Later, when he was without work he fearlessly began to make his own contacts and succeeded in getting a clerical position at a good salary.

Photograph lent by U. S. Office of Education

MODEL ships and planes are fun to build in this orthopedic school. Working together helps crippled children to adjust to life after they leave school.

Instead of being a burden to his parents, Eddie is carrying his share of the family responsibility; he goes about wherever he wishes, meets people easily and has girl friends. Six years of medical and social-service treatment have meant the difference between happy, productive adulthood and the barren future that he himself anticipated when he came to the clinic, saying, "There is nothing in life for me except selling pencils on a street corner."

The worker evaluated the social adjustment of the 60 young people at the end of the 5 years during which they had been receiving social treatment, and classified them in three groups, maladjusted, well-adjusted, and—the middle group—fairly comfortably adjusted.

Twelve of the 60 boys and girls were classified as maladjusted; 10 were classified as well-adjusted, and the remainder, 38, as fairly comfortably adjusted.

Maladjustment

The maladjusted young people include those who are shy and seclusive or too aggressive; those who are overdependent on their parents; and those who show marked feelings of resentment, self-pity or depression. Of these maladjusted young people, 8 were between 14 and 16 at the time this report was written, and the other 4 were over 19. Nine of them had become handicapped at the age of 6 or younger.

Only one of these maladjusted boys and girls had understanding parents. This child was a girl who was severely crippled from infantile paralysis and could not move without help. In spite of her parents' encouragement and interest, the girl remained withdrawn and shy.

One maladjusted girl had a younger sister toward whom their father showed favoritism. This caused the crippled girl to adopt an attitude of withdrawal from social life. Her original self-consciousness increased, for in her crippled condition she could not hope to compete with her sister.

Ten of the 12 maladjusted boys and girls had overprotective and overanxious parents. This attitude constitutes a real danger to a crippled child's emotional growth, as the child may be prevented from gaining even the limited self-satisfaction that his handicap allows.

Since most of the children with overprotective parents are still under 16 years of age, it is possible that as they grow older they will become more and more independent.

One of the 12 maladjusted children, Elena, has had a very unhappy home life. Her father is alcoholic and unstable. He deserted her mother to live with another woman, and the mother's resentment has had its effect on Elena's life. Her mother would often say to her, "You are a cripple."

The girl visits her father occasionally, but he is ashamed to go out with her because of her crippled condition.

The social worker has recognized Elena's emotional needs, and has stood by her as an understanding friend, to whom the girl would talk about her problems.

Elena has gained some measure of social adjustment, but is still afraid to go out alone, even though the orthopedic surgeon says she is physically able to do so.

Fairly comfortable adjustment

In 38 cases both the parents and the child were given as much help as they would accept from the social worker and on the whole were making a fairly comfortable adjustment. A patient was considered to be "fairly comfortably adjusted" if he had been able to make some adaptation in his personality, so as to compromise with his handicap.

Much can be accomplished despite unfortunate parental attitudes and undesirable environments, and in 10 of the 38 cases of fairly comfortable adjustment the parents had accepted the child's handicap as though they said, "Here it is and we are resigned."

The common factors in effecting adjustment in these 38 cases were the adolescent's inner urge for growth and independence and the social worker's individual work with him, or with his parents, or with both.

Seven of the children in this group of 38 had parents who made the child feel unwanted and unloved. In 21 cases the child was subjected to antagonism by one parent and overprotection by the other.

One crippled boy was not allowed by his father to be present when there was company; he was hidden in another room. The mother would try to make amends to the boy by giving him candy and other sweets. As a result the boy became very heavy, a problem because of his paralyzed legs.

An example of the children that were considered fairly comfortably adjusted is shown in the story of Jake.

Jake, throughout his school years, had no associates outside of the home. He did not use his crippled arm at all. His parents were passive about his handicap. He had a strong feeling against associating with crippled children.

Apparently in an effort to gain a place with a group, he became involved in stealing.

The social worker helped him get a job where the pay satisfied him and he began using the arm which he had previously considered "of no use."

He did not welcome the social worker's effort to interest him in the boys' club and still is withdrawn from social contacts, but at 17 he is adjusted to his employment and has accepted his handicap as a reality.

Good adjustment

The 10 patients considered well adjusted have a wholesome attitude toward their handicap, have a wide range of interests, including participation in social activities and in employment, and do not show any appreciable behavior difficulties. In 8 of the 10 cases, the parents appear to be sufficiently well-adjusted to be able to maintain a constructive attitude toward the child and to stimulate him to as much participation as his handicap permits.

The mother of one boy in this group was overanxious about him and also showed favoritism to his sister, but the boy was able to derive sufficient constructive satisfaction from his father.

In these cases the social worker had excellent relationships with the patient and the parents. She was sought for the most part in times of crisis, such as proposed surgery or other long-time treatment. After she had helped relieve the parents' anxiety, her role became a supportive one.

In these 10 cases in which the boys and girls were considered to be well-adjusted we find evidence that well-adjusted parents helped the young people to develop their own potentialities and to aim at goals within their capacities. The parents of Charles, a severely handicapped boy, are a good example of this.

At the age of 19 Charles is able to engage satisfactorily in strenuous physical activity.

He was born with an anomaly of the right foot, which was rudimentary and attached to the hip. In addition, he had only three fingers on his left hand.

When he was 6, Charles begged his mother to allow him to ride a bicycle, at 8 he wanted to ice skate, and at 16 he selected driving a car as his next feat. Each time he wished to try a new activity, the parents suggested that he might try the new experience as soon as he felt ready.

Charles now drives a car, rides a bicycle, and ice skates, using a special crutch with a spike. He is well liked by boys and girls and is a leader in church and neighborhood groups. He is self-confident, successfully employed, and enjoying a full life within the limits of his handicap. Throughout we can see the constructive attitude of both parents toward Charles from his very early years. Though the goal seemed beyond the patient's limit, the parents neither discouraged nor encouraged his hopes but held them as a possibility. if and when he was able. This shows their acceptance of Charles as a normal child rather than a cripple.

Compensate for limitations

These 60 case studies show that handicapped adolescents have a deep feeling about their disability and their lessened opportunity for social life, employment, and marriage. Development of positive personality factors helps them to compensate for physical limitations and to live in the everyday world with a maximum of usefulness and comfort to themselves and to the community. This development can be helped by working with the child in his home, his school, and his community, as early as possible, and this is definitely within the province of social service.

The community has already assumed great responsibility for the crippled child's medical care. It is a long and expensive program, involving private as well as public funds. If the program of an orthopedic agency is to be an adequate one, the challenge of treating the whole child should be accepted.

Reprints available on request

IN THE NEWS

New York State Labor Department Reports Upon Child Labor in Agriculture

The New York State Labor Department now has in press "Seasonal Farm Labor on Fruit and Vegetable Farms, New York State, 1945"—a comprehensive study of employment, living conditions, and earnings of children in agriculture in the State. The report combines data on workers under 18 years of two types: (1) "Day haul" workers, who are transported daily to the farms from the cities by truck or bus, and (2) migrant workers, who live in labor camps in the harvesting season.

The report quotes Governor Dewey's message to the legislature, January 1945, as follows: "Since * * * seasonal workers are necessary to our economy and welfare, it is the responsibility of the State of New York to insure for them acceptable living and working conditions."

"The New York State child-labor law," the report goes on to say, "applies to child workers on the farms as well as in factories; * * *. A large part of public opinion, associating farm labor with work on small home farms, has been inclined to consider such work as a rather pleasant and not too arduous task for children, ignoring the fact that in modern industrialized agriculture such labor can be quite as difficult and exhausting for a child as factory work."

Expressing its concern about the "ever-growing employment of child laborers and migrants in industrialized agriculture and the conditions of their employment," the report describes the start, in the summer of 1945, of a State-wide informational and educational campaign among fruit and vegetable growers, farm workers, interested agencies, and the public.

One of the first steps in this campaign was a conference called by the State labor commissioner in Syracuse last July, at which he outlined the department's farm-labor program. This outline is given in the appendix of the report, which also contains a summary of the New York State labor laws affecting farm workers.

That the State labor department of one of our most important agricultural States is beginning to take more responsibility for the protection of agricultural child laborers is an encouraging sign.

Louise Q. Blodgett

State and Territorial Health Officers Meet With Chief of the Children's Bureau

Development of health services for school children under State programs of maternal and child-health services under the Social Security Act was discussed by the Association of State and Territorial Health Officers at its conference with the Chief of the Children's Bureau April 10 at Washington.

Among the other subjects discussed were: (1) Recommended principles for the development of dental programs for children and (2) the Academy of Pediatrics study of child-health services.

The meeting with the Children's Bureau was part of the forty-fourth annual conference of State and Territorial health officers with the Surgeon General of the United States Public Health Service.

State Committees on Children and Youth

California

The California Youth Authority in March 1946 published the first issue of a new quarterly, "Community Organization for Youth Services."

Georgia

The Youth Division of the Georgia Citizens Council, through its Parents and Community Cooperation Section, has recently issued a leaflet, "Developing Georgia's Youth Through Guidance."

Kansas

The executive committee of the Kansas Council for Children at its January 27 meeting voted to issue a revised edition of its directory of State organizations and agencies concerned with children, and a bimonthly news letter, and to work with the youth-conservation committee of the General Federation of Women's Clubs.

The council has prepared a statement of the major needs of the children of the State, in terms of social welfare, health, and educational legislation. Instead of urging a complete revision of the juvenile code at this time the council will press for some modifications of the present laws. Recommendations for legislative action, approved on March 23, 1946, cover the needs of children's institutions, including the State training schools, the State orphans home, and the State receiving home; adoption; child placing; juvenile court; probation; extending and improving school facilities; and provision for premarital health examinations. The council has also made recommendations to the State board of social welfare for administrative improvements in the child-welfare program.

It recommends also that an adequate appropriation be made for an intensive study of the juvenile laws and that a commission be appointed to prepare a new juvenile code for the 1949 legislature.

Michigan

The Michigan Youth Guidance Commission in April issued the first number of a news letter, "Youth Guidance in Michigan." It also is distributing "Suggestions for the Organization and Development of County and Community Youth Guidance Committees or Councils," and has just issued a progress report covering the period July 1, 1945, to April 1, 1946.

Minnesota

The Governor's Advisory Committee on Youth, in its report to the Governor February 26, recommended that a State-wide commission provided with staff assistance be appointed, to be known as the Governor's Commission on Youth. It recommended also that community youth councils affiliated with the commission be developed.

Mississippi

Mississippi's 1946 legislature has enacted into law several of a series of measures recommended by a commission that was appointed by the Governor late in 1945. These include a new juvenile-court act, an act increasing the powers of State and local departments of public welfare, and an act establishing a Children's Code Commission.

The Children's Code Commission is to consist of nine members, to be appointed by the Governor. The commission is directed to make a study of: (1) Conditions in the State affecting the welfare of children; (2) the functions and facilities of the various institutions and agencies in the State charged with the care, control, protection, and rehabilitation of children; and (3) existing laws pertaining to and affecting children. The commission may enlist the aid of other public and private agencies concerned with the welfare of children. The commission is to report and make recommendations to the Governor and the legislature concerning legislation.

New York

The New York Times on April 9 reported the establishment of a Westchester County Youth Bureau to originate and coordinate guidance programs to curb juvenile delinquency. Half the cost will be borne by the State from funds administered by the New York State Youth Commission.

Edith Rockwood.

Temporary Social Commission of United Nations Meets

The Temporary Social Commission, which was appointed by the Economic and Social Council of the United Nations, met in New York, April 29 to May 17. The purpose of the Commission is to make a general review of international organization in the field of social welfare and to study problems not dealt with by existing organizations. Katharine F. Lenroot, Chief of the Children's Bureau, served as secretary.

Children of Migratory Farm Workers in New York State to Benefit From New Law

Children of migratory agricultural and food-processing workers should find life in New York State less uncertain after this. The State labor law has recently been amended and now requires labor contractors bringing such workers into the State to submit to the State industrial commissioner, ahead of time, whatever information on the employment of the migrant workers the commissioner prescribes, such as wages, housing, and working conditions. The registrant must also give a copy of this information to each worker before the work begins, and also keep a copy posted in each camp. The law reads as follows:

"Each person who employs, recruits, transports, and brings into the State or is responsible for bringing into the State 10 or more out-of-State migrant farm or food-processing workers who are residents of the United States, shall, in each instance prior to the importation of such workers, register with the industrial commissioner and submit facts on wages, housing, working conditions, and such other information as the commissioner may prescribe. Copies of this information shall be made available by the commissioner to each such registrant, who shall (1) give a copy to each worker preferably at the time of recruitment and in any event not later than the time of arrival in the State and (2) post and keep posted conspicuously at least one copy at all times in any camp in which such workers are housed. Upon registration with the commissioner as provided above, he shall submit to each registrant pertinent information concerning workmen's compensation insurance and farmers' liability insurance with medical payments, including the rates for such protection."

This measure is one of those recommended by the Committee on Migrant Camps of the New York State War Council which made tours of inspection of migrant camps and in 1944 and 1945 studied the methods used by farm-labor contractors in two areas in central New York.

C. A. R. E. for Europe's Hungry Children

Substantial packages of food—enough to supply a child with a daily diet of 2,000 calories of wholesome food for nearly 3 weeks—can now be sent to Europe through C. A. R. E. (Cooperative for American Remittances to Europe).

Nonprofit agency

C. A. R. E. is a nonprofit agency organized by 24 American agencies engaged in foreign relief. It has been approved by the President's War Relief Control Board, the Department of State, the Department of Agriculture, the Office of War Mobilization and Reconversion, the War Assets Corporation, the Quartermaster General of the United States Army, and the United Nations Relief and Rehabilitation Administration.

Total cost, $15

The cost of a food package—$15—covers contents, packing, shipping, and delivery. Packages are exempt from foreign customs duties and rationing regulations. By the end of April, C. A. R. E. was in operation in seven European countries — Czechoslovakia, Finland, France, Italy, Netherlands, Norway, and Poland—and arrangements were being negotiated with other countries.

To send a package all that is necessary is to fill out a single "food-remittance application," and mail it with a money order or check for $15 to C. A. R. E., 50 Broad Street, New York 4, N. Y. Food-remittance applications may be obtained from C. A. R. E. or from local banks, churches, relief organizations, and labor unions.

By buying standard food packages known as "10–in–1," which were designed to feed 10 American soldiers for 1 day, C. A. R. E. is able to supply at this price nearly 30 pounds of food, as follows:

	Pounds (net)
Solid meat, stews, and hashes	9.8
Cereal and biscuits	6.5
Fruit jam and pudding	3.6
Vegetables	2.3
Sugar and candy	3.9
Cocoa, coffee, and beverage powders	1.1
Evaporated milk	.8
Preserved butter	.5
Cheese (included in one menu)	.4

In addition the packages contain soap, paper towels, and toilet tissue.

As the milk content of the packages is relatively small, many persons will wish to send supplementary packages containing evaporated milk for children independently through the parcel post.

The member agencies of C. A. R. E. are:

American Christian Committee for Refugees, Inc.

American Friends Service Committee.

American Jewish Joint Distribution Committee, Inc.

American Relief for Czechoslovakia, Inc.

American Relief for France, Inc.

American Relief for Norway, Inc.

American Relief for Poland, Inc.

Church Committee on Overseas Relief and Reconstruction.

Committee on Christian Science Wartime Activities of the Mother Church.

Congregational Christian Service Committee.

Cooperative League of the U. S. A.

International Rescue and Relief Committee, Inc.

Labor League for Human Rights, AFL.

Mennonite Central Committee.

National CIO Community Services Committee.

Paderewski Testimonial Fund, Inc.

Save The Children Federation, Inc.

Tolstoy Foundation, Inc.

United Ukranian American Relief Committee.

Unitarian Service Committee.

United Lithuanian Relief Fund of America, Inc.

United Yugoslav Relief Fund of America.

War Relief Services—National Catholic Welfare Conference.

YWCA—World Emergency and War Victims Fund.

New Mississippi Law on Administration of Child Welfare

Mississippi's new "Administration of Child Welfare Act," which was sponsored by the State Children's Code Commission, broadens and clarifies the responsibilities of the State and county departments of public welfare. The new act specifies that the authority of the State department to administer or supervise public child-welfare services covers the services, responsibilities, powers, and duties invested by the act in the county welfare departments. The law authorizes the State department of public welfare not only to supervise, as before, the care of dependent and neglected children in foster family homes and institutions, but also to provide such care. In addition, it brings private child-placing agencies and institutions under the licensing power of the department; this power formerly extended only to child-caring agencies and institutions and boarding homes.

The new measure clarifies the responsibility of county departments of public welfare with respect to direct care of children by giving every such department specific authority to place in suitable institutions or private homes children found by it to be dependent or without proper care. It also gives the county department authority to accept, through its designated employees, custody or guardianship of any child when the department is appointed as custodian or guardian in the manner provided by the laws governing such appointment. The county supervisors are to set aside the necessary funds, which are to be administered by the county departments. The new law repeals a law that established county children's aid funds and set procedure under which chancery courts granted aid from such funds. It also repeals the statutory provisions which permitted the county boards of supervisors to apprentice "poor children."

Freda Ring Lyman.

Summer Courses

Barnard College, Columbia University, New York 27, in cooperation with the *New York School of Social Work*, will conduct an institute on community problems to train people already active in community affairs (June 10 to 28).

New York School of Social Work, Columbia University, New York 10, will hold three series of summer institutes dealing with various aspects of social work. (Series I, which includes "Current Problems in Child Welfare," and "Problems and Contributions of Case Work in Children's Institutions," July 15–26; Series II, July 29–August 9; Series III, August 12–23.)

Mills College, Oakland, Calif., will offer a course covering physical, mental, and social development of children supplemented by directed observation of children 2 to 7 years of age, which is designed to serve students with a general interest in the growth and development of children. (July 6 to August 17.)

Louisiana State University School of Social Welfare, Baton Rouge, will offer a 3-week, a 6-week, and a 9-week summer term beginning June 10; also a 3-week course beginning July 1. The subjects include juvenile delinquency, child-welfare problems, children in foster care, and community welfare planning.

FOR YOUR BOOKSHELF

BETTER HEALTH FOR RURAL AMERICA; Plans of action for farm communities. U. S. Department of Agriculture, Washington, 1945. 34 pp. 20 cents.

Farm people are deeply concerned about their health and their medical services, says the introduction to this bulletin. There are many groups planning, and many different ideas, it says, but farm people are more or less agreed on what they want. (1) They want more doctors, nurses, and dentists in their communities; (2) they want more hospitals and better sanitary facilities; (3) they want more preventive medicine and public-health clinics; (4) they want easier ways of paying their doctor bills; and (5) they want all the benefits of first-class medical science that they read about.

What are some of the reasons that farm people have these wants? What are the health problems about which they are concerned? What has already been done to tackle these problems? What can farm people do now to solve them? This publication sets out to help in answering these and related questions.

The bulletin goes on to remind us that even the big cities ought to be concerned about rural health because city populations are made up largely from people who have left the farms.

THE ROLE OF THE BABY IN THE PLACEMENT PROCESS. Pennsylvania School of Social Work of the University of Pennsylvania, Philadelphia 3. 113 pp. 85 cents. Includes three papers, "The Integration of Agency Services in Placement of Babies," by Mary Frances Smith; "Helping the Baby To Move Through the Temporary Foster Home," by Louise Leatherland; and "Helping the Baby to Move Into the Adoption Home," by Florence M. Pile; as well as introduction and conclusion by Jessie Taft.

"To the uninitiated," says Jessie Taft in her introduction to this pamphlet, "these records of baby placement may seem like fairy tales invented to make a traumatic situation less painful, * * * but to trained workers who have learned to accept child placement as a legitimate service and who have lived through its detail unflinchingly, they * * * offer a new revelation of the constructive possibilities in the placement of babies."

Miss Smith points out that placement is not the responsibility of the agency alone and indicates the agency's part and that of the parents. In some parts of this article discussion of agency procedures and of the function of the worker tends to obscure the role of the baby.

Every worker who has had considerable experience in placing infants will recognize the validity of Miss Leatherland's observations of the reactions of an infant in his transfer to a foster home, in his clinic experiences, and in his relationships with his workers.

Not all agencies will agree with the author that it is desirable for a baby to have one worker and the parents another.

Miss Pile's experience has led her to believe that the child should be the one to move toward the adoptive parents rather than having them go to him, in a playroom or elsewhere; that there is definite value in having the visits of the child with the adoptive parents take place in the agency office; that it is more helpful for the child to go in with the adoption worker to the room where the adoptive parents are waiting, rather than with his own worker, who is identified with his former home; and that there are instances in which both the child and the adoptive parents are ready for the placement at the time of the first visit.

In the conclusion Miss Taft emphasizes that "human beings are not just the passive victims of trauma from birth to death. They do find fulfilment in experiences that are hard to leave."

I. E. S.

WHY CHILD LABOR LAWS? Publication 313. U. S. Department of Labor, Children's Bureau, Washington, 1946. In press. Copies will be available without charge on request to the Children's Bureau.

An illustrated primer on the facts and philosophy of child-labor regulation, entitled "Why Child Labor Laws," not only high lights the "why" of child-labor laws, but also tells how these laws regulate child labor through Federal and State authority, where the country stands now on child-labor standards, and what employment certificates mean. This material was originally drafted at the request of a national organization, which needed a statement to help its local leaders understand the essentials of child-labor regulation. It has been rounded out into a story that should help every group and individual who wants to understand why we have child-labor laws and how they operate.

Not only will individuals interested in improved legislation get help from this leaflet, but also social workers, factory inspectors, counselors, parents, teachers, and young people themselves. It was written by Mrs. Lucy Manning of the staff of the Industrial Division of the Children's Bureau.

E. S. J.

YOUR COMMUNITY AND ITS YOUNG PEOPLE; their employment and educational opportunities. Prepared by the Interagency Committee on Youth Employment and Education. Publication No. 316. U. S. Department of Labor, Children's Bureau, Washington, 1946. In press. Copies will be available without charge on request to the Children's Bureau.

The Federal Interagency Committee on Youth Employment and Education, sensing the need to share with community and other groups its interest in studying and planning to meet the educational and employment needs of young people, has set forth in this leaflet some of the questions with which it has been grappling during the past year.

The leaflet is designed chiefly to help community groups to find out what their present needs are and to help them think through some of the policies that should guide expansion of existing services or the setting up of new ones. Some of the broad questions dealt with are:

What is the employment situation now for young people?

Is the community educating all its young people?

How is the present employment and school-attendance situation for young people likely to change?

Do the school opportunities attract young people and serve their needs?

Would financial aid to students help to keep more young people in school?

Are there counseling services to help young people, both those in school and those out of school, to make wise choices leading to good occupational and social adjustment?

Are placement services that include job counseling available for young people?

Can sufficient suitable job opportunities be provided for youth who are ready for them?

What action is needed to deal with these problems?

The leaflet includes a statement of suggestions for its use and the committee invites groups to send in to it their ideas and information about plans they are making.

As was announced in the September 1945 issue of *The Child*, the Interagency Committee on Youth Employment and Education was organized in April of that year. It is now composed of representatives from the following Federal agencies: the Department of Agriculture; six bureaus of the Department of Labor (Apprentice Training Service, Bureau of Labor Statistics, Children's Bureau, Division of Labor Standards, U. S. Employment Service, and Women's Bureau); and three bureaus of the Federal Security Agency (Office of Community War Service, U. S. Office of Education, and Social Security Board).

E. S. J.

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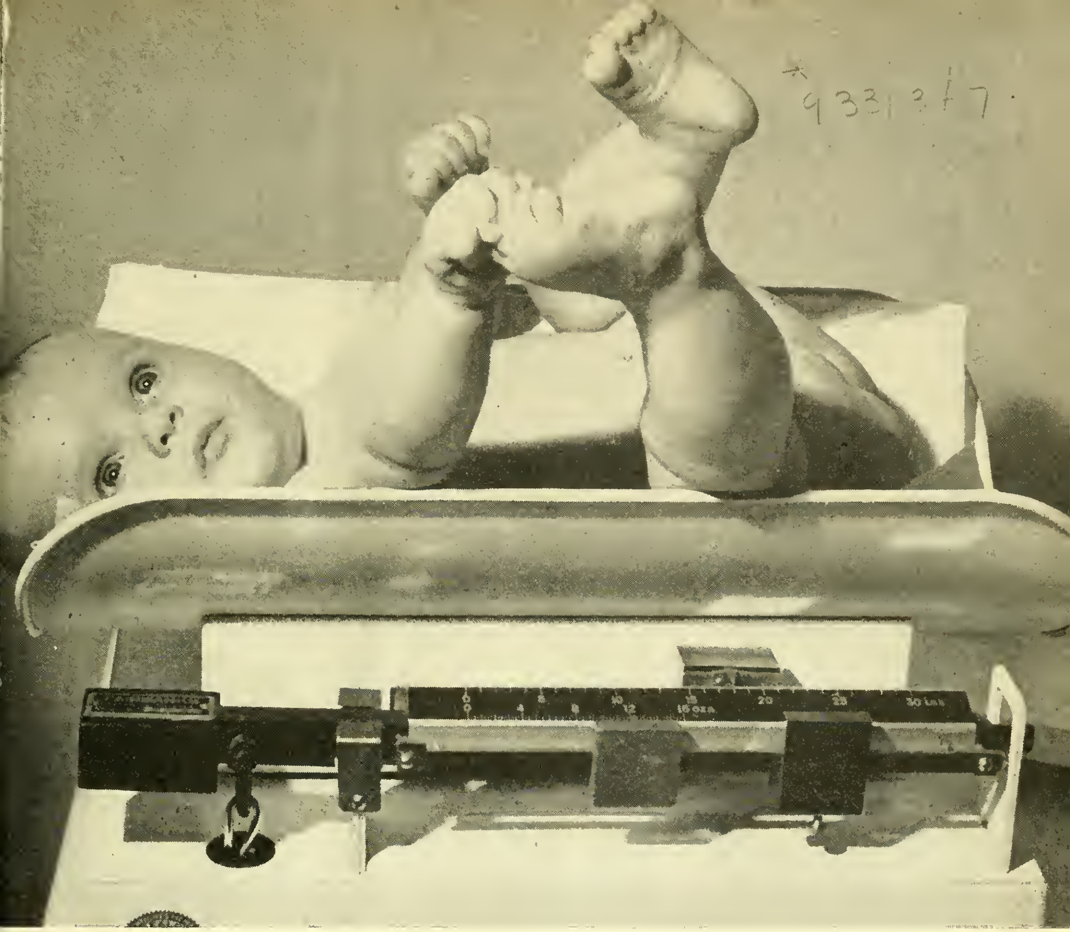

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The CHILD

CHILDREN'S BUREAU • U. S. DEPARTMENT OF LABOR

- CHILDREN STILL LABOR IN THE FIELDS
- EPILEPTIC CHILD CAN LEAD A NORMAL LIFE
- FOURTH BORDER HEALTH CONFERENCE

1946

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The CHILD

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The picture on the cover, of an infant being weighed, is a Standard Oil photograph, by Bubley.

U. S. DEPARTMENT OF LABOR
L. B. Schwellenbach, *Secretary*

CHILDREN'S BUREAU
Katharine F. Lenroot, *Chief*

CHILDREN WITHOUT A COMMUNITY

"Our Concern Every Child," the theme of the White House Conference on Children in a Democracy, will not be realized as long as it fails to reach and serve the children in the families that are always on the move, following the crops from one place to another.

Concern for the welfare of children ordinarily is translated into services for them through action by their community. But what of the hundreds of thousands of American children who have no community? How about their living conditions, in shelters and lean-to's, without sanitary facilities? What about their health, without medical services? Besides, do not these children need welfare services, perhaps even more than the children who have permanent homes in the community? And what about the lack of education for these children, many of whom work instead of going to school? This lack is perhaps the most far reaching of all in its effects.

In recent months *The Child* has been presenting a series of articles on children of migratory agricultural laborers, describing certain efforts to meet some of their needs for health services, opportunities for schooling, and day care for the younger children while their mothers work. (An article in the present issue takes up the work of the children.)

Leadership in beginning to meet some of these needs was given by the Farm Security Administration about a decade ago. Later some of the programs started by this agency were carried on by wartime agencies and private organizations. But withdrawal of wartime funds and programs has added to the burdens on the groups that are continuing their efforts to give these services.

As a result of this ever-changing situation, the outlook for providing services is far less bright than past accomplishments might suggest. Vast numbers of these children have never had such services at any time. And not until Federal and State Governments and local public and private agencies provide continuing and more comprehensive programs will migratory children receive the services that they need.

The special need of these children has its roots in the economic condition of the families—the condition that causes them to follow the crops and that forces the children to labor in the fields.

Until child workers are out of the fields, as they are now for the most part out of the factories, we, the people of the richest country in the world, have cause for shame. Why do children labor at crop picking? Because their parents do not earn enough to support them and because by and large child-labor laws offer them little protection. The family wage used to be the wage pattern of our textile mills; it still is the pattern for many agricultural occupations.

Too little has been done to regularize employment of migrant agricultural workers or to bring their children under the protection of child-labor laws.

Before the injustices which are endured by migratory children can be ended, representatives of Federal, State, and local agencies concerned with labor, health, welfare, education, farm placement, and transportation, will have to get together and work out patterns of employment that will enable these children to enjoy the privileges that every child should have. The interest of every citizen in this goal will hasten its achievement.

Katharine F. Lenroot

Katharine F. Lenroot,
Chief, Children's Bureau.

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CHILDREN STILL LABOR IN THE FIELDS

Few States have laws that protect children employed in agricultural work

by IONE L. CLINTON
Industrial Division
U. S. Children's Bureau

●Agricultural work is not easy, as anyone who has done such work for long hours at a time knows. Yet hundreds of thousands of children—some as young as 6—follow the crops with their families and work in the fields to help produce the food we eat.

The crops they follow are those that are worked on by hand. The growers who raise this kind of crop—beans, cotton, potatoes, prunes, sugar beets—always need a great many extra workers at harvest time.

Some of the working children in these families are as young as 6 years; an occasional child who is even younger than 6 is found helping to pick. In a study made in Hidalgo County, Tex., in 1941, the Children's Bureau found that more than three-fourths of the 600 migratory children 6 through 17 years included in the study worked in the fields. And it wasn't just the older children. More than half of the 8- and 9-year-old children worked; and more than 15 percent of those 6 and 7 years old. The New York State Department of Labor, in 1945, interviewed 600 migrant workers in the course of a larger study and found that one-fourth of the workers were children under 14 years of age. Thirty-two of these child workers were under 10.[1]

The work is in general very hard on the children, especially the younger ones. They have to do the same thing over and over again, hour after hour, day after day, often in a stooping or a reaching position. They may pick beans in the hot sun or top sugar beets in freezing weather. They sometimes pick berries during a rain or right after it, when the ground and plants are wet. They may get "bean poisoning" from picking certain kinds of beans. They may strain themselves lifting boxes full of fruit or vegetables or dragging bags full of cotton. They almost never get a proper lunch, and there may be no safe drinking water in the fields. The trucks they go back and forth from the fields in may be unsafe and overcrowded.

These children, along with their parents, usually work long hours, and many of them spend additional time daily going to the fields and back again. Besides, when the work day is over and they are ready to go home, they may have to wait for some time before the truck can take them, if it is being used to carry the fruit or vegetables from the fields to the cannery or the packing shed.

Children in these families begin to work when they are very young, and keep on working, because the older members of the family usually cannot earn enough to support the family. Even when piece rates are comparatively high, the crop good, and the weather favorable, so that the family can earn a fairly good sum over a limited period, the money almost always is used up during periods when earnings are cut off because there is no work, or are cut down because of low piece rates, or a poor crop, or bad weather.

In spite of the hard work these children do, they are able to earn very little for their efforts. The workers are usually paid at piece rates, and children as a rule can pick less than adults—the younger the child the less he can pick. In the New York study it was found that the hourly earnings of the children under 10 were less than a third of those of the 16- and 17-year-olds.

Industrialized agriculture

Migratory children have been employed in agriculture in large numbers ever since general farming and the family-operated farm began to give way to industrialized agriculture—mass production of specialized crops that need hand labor. Besides the children in migratory families, thousands of local children also work in these crops at seasonal peaks. Children from neighboring farms and nearby communities go to the fields from their homes early in the morning and return at night. These children, although many of them are far too young to work, do not, on the whole, start work at so early an age as the migratory children are likely to do. Besides, the local children are very unlikely to work most of the year, as some migratory children do when they pick several different crops in different places. Much of the work these children do is as exacting and as unsuitable for children as is factory work, from which Federal and State laws now generally protect them. And it is not, as many think, the same as the work a farm child does on his own home farm.

The child on his father's general farm works at a variety of jobs. Usually his parents give him jobs that they think he is old enough and strong enough to do. He usually goes to school and does his work after school and during vacations.

But the child who is employed during seasonal crop peaks labors steadily at a tedious task, often one that is beyond his strength. He may stay out of school to work. If he is a migrant child his schooling is almost sure to be seriously curtailed. (See *The Child*, November 1945.) He jeopardizes his health and general welfare by too arduous work at too early an age.

Children cannot really be protected from employment at harm-

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[1] Seasonal Labor on Fruit and Vegetable Farms, New York State, 1945. Surveyed by New York State Department of Labor, Division of Industrial Relations, Women in Industry and Minimum Wage. New York City, 1946.

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ful work without legislation that prohibits such employment—in agriculture as well as in industry. Yet, when legislation to regulate the employment of children in agriculture is being considered, many people react by thinking only of the work of the children on their home farms. As a result, child agricultural laborers are given very little legislative protection against harmful employment in agriculture.

Two Federal acts apply to employment of children in agriculture but to a limited extent.

The Sugar Act of 1937, which provides for payments of benefits to producers of sugar beets and sugarcane, makes these producers eligible for full benefit payments only if they do not employ children under 14 years of age in production, cultivation, or harvesting, and do not permit those between 14 and 16 to work longer than 8 hours a day. These restrictions do not apply to children whose parents are growers owning 40 percent or more of the crop.

Another Federal act, the Fair Labor Standards Act of 1938, has child-labor provisions, administered by the Children's Bureau, which include limited coverage for employment in agriculture. These provisions establish a basic minimum age of 16 years for children employed in or about establishments producing goods for shipment in interstate or foreign commerce. But this minimum applies to agricultural employment only on the days and during the hours when children are legally required to attend school. And school-attendance laws in different States vary widely in their provisions. They vary with regard to the ages at which children are required to attend school, the length of the school year, the reasons for permitting release from school, and the periods for crop vacations. Thus, large numbers of child workers on farms do not benefit from this legislation.

Only four States—California, New Jersey, New York, and North Carolina—and the District of Columbia, Hawaii, and Puerto Rico have child-labor laws with a minimum age for agricultural employment outside of school hours as well as during school hours.

Four other States—Florida, Massachusetts, Ohio, and Pennsylvania—set a minimum age for such employment during school hours only. Eighteen other States have general minimum-age standards, which are nominally broad enough to apply to all employment during school hours, and which might be interpreted to apply to agricultural employment. The remaining 22 States and Alaska have no minimum-age standard for agricultural work.

Enforcement difficult

Even where laws especially apply to the employment of children in agriculture, enforcement has too often been lax or nonexistent. It has been hard to enforce the laws for the same reasons it has been hard to enact them. Public opinion may not support enforcement, may be indifferent to it, or may even oppose it.

At the beginning of the war more children than ever before started working in agriculture to help produce the extra food needed. War demands for more and more children and youth to do agricultural work even brought about emergency legislation to relax existing child-labor standards in a number of States.

Two States—New Jersey and New York—which have good basic laws in regard to agricultural employment enacted such emergency

TOMMY is bending over to pick up potatoes from the loosened soil. As he puts the potatoes into the basket he shifts from one stooping position to another. He will lift the filled basket and carry it to the end of the row. (North Carolina)

Photograph by Farm Security Administration

MARGARET is resting for a minute or two. She has been on her knees in the damp soil picking strawberries since 5 in the morning. Berries must be picked from the same patch every day or two during the 6 weeks' season. (Louisiana)

Photograph by R. Lee for Farm Security Administration

legislation, permitting children 14 years or over to be released from school to do farm work, under controlled conditions and for limited periods of time only. In the enforcement of this emergency legislation officials have gained valuable experience in techniques of administering child-labor provisions to regulate agricultural employment.

Public awakened

The wartime increase in agricultural employment of children—many of them city children who had never before done farm work—gradually brought about a change in the indifferent attitude of the public toward conditions of work in agricultural employment. Many realized for the first time what work in the fields does to a child.

As a result a few communities began to make efforts to work out methods of controlling and regulating not only the age at which children could start working but also the working conditions of the older children. Standards for agricultural employment, developed at the beginning of the war by the Children's Bureau in cooperation with other Federal agencies and several national organizations, gained some support and acceptance in various communities.

These voluntary standards include such provisions as a 14-year minimum age, an 8-hour maximum day, guaranteed and fair earnings, safe working conditions, and safe transportation. Communities that made efforts to control the agricultural employment of children in accordance with such voluntary standards also gained experience in administrative methods that can be useful in the enactment and enforcement of legal standards.

It is important that the public interest that was aroused during the war in regard to the need for safeguarding children from undesirable employment in agriculture should not be allowed to subside. An example of how such interest is being built upon can be found in New York State. In 1945 the State labor department for the first time assigned a large group of investigators to make an agricultural survey among local and migratory workers. They visited farms and labor camps to find out about conditions of employment in agriculture, to give parents and growers information in regard to the provisions of the child-labor law, and to prepare the way for enforcement in 1946.

It was possible to do this in New York State because the basic child-labor law is good. This law sets a minimum age of 16 for employment at agricultural work during school hours and a minimum age of 14 for employment outside school hours, and requires employment certificates for children 14 and 15 employed outside school hours at such work. (The emergency legislation providing for some relaxation of the 16-year minimum has been extended to July 1, 1947.)

The States that do not have legal standards for the protection of children from undesirable employment in agriculture will need to start working toward such controls.

Whatever acceptance of voluntary standards there was during the war in these States may help toward the achievement of protections for all children employed in agriculture, both local and migratory.

(This is the fourth of a series of articles on children of migratory workers.)

Reprints available on request

MARY is crouching down to pick "bush beans." This is one of the simplest agricultural operations, and many very young children do this work. Although it is simple, it is hard work when it is done hour after hour, day after day. (New Jersey)

Photograph by John Collier for Farm Security Administration

JUAN is reaching down to stick his heavy hooked knife into a 2- or 3-pound sugar beet so that he can lift it, catch it with his left hand, brace it with his raised left knee, and slice off the beet top with a quick, strong, downward stroke. (Minn.)

Photograph by R. Lee for Farm Security Administration

FOURTH BORDER HEALTH CONFERENCE

U. S.-Mexico Border Public Health Association holds annual meeting

by ***ELISABETH SHIRLEY ENOCHS,*** ***Director***
Inter-American Cooperation Unit, U. S. Children's Bureau

● Maternal and child health and welfare was the subject of discussion at one of the six round tables which met in connection with the Fourth Annual Border Health Conference held in El Paso, Tex., and Ciudad Juárez,, Chihuahua, Mexico, April 29 and 30 and May 1, under the auspices of the United States-Mexico Border Public Health Association.

This was the second time that problems affecting mothers and children living on both sides of the Rio Grande had been given a place on the program. At its closing session the Conference gave its approval to a report presented by the round table, listing eight recommendations designed to strengthen the existing programs and to develop additional resources through which cooperation between Mexico and the United States in promoting the health and welfare of mothers and children along the border may be facilitated.

New section established

In presenting the report to the Conference, the newly elected president, Dr. Gustavo Rovirosa of Ciudad Victoria, State of Tamaulipas, Mexico, suggested that the first recommendation be put in the form of a formal resolution establishing the section on maternal and child health and welfare as a definite part of the Association. Approval of this resolution was followed by approval of the balance of the report, which outlines the functions and organization of the section and types of cooperative activity which might be carried out under its auspices.

The action of the Conference was evidence of the steady growth of interest since last year's meeting, when maternal and child health and welfare was given a place on the program of the Conference for the first time, although in an informal way. It was also proof of the support of the retiring president, V. M. Ehlers, Technical Supervising Engineer of the Texas State Department of Health, and other officers of the Association, and of the new president, Dr. Rovirosa of Mexico.

In developing plans for this year's meeting, the acting secretary of the Association, Dr. James A. Grider, Jr., representative of the Pan American Sanitary Bureau in El Paso, had again invited Dr. Pedro Daniel Martínez, Director General of Child Health and Welfare of the Department of Public Health and Welfare of Mexico, and Katharine F. Lenroot, Chief of the Children's Bureau of the United States Department of Labor, to serve as co-chairmen of the round table. As Miss Lenroot had been designated by the Department of State to serve as Secretary of the Meeting of the Temporary Social Commission of the Economic and Social Council of the United Nations, the writer was asked to substitute for her at the Border Conference.

Mexico was represented at the meeting of the round table by an outstanding delegation from Federal agencies in Mexico City and departments of public health of the Mexican border States.

Accompanying Dr. Martínez were Dr. Leopoldo Chávez, Chief of the Bureau of Social Prevention, of the Department of the Interior of Mexico; Dr. Hermilo L. Castañedo, pediatrician on the staff of the Children's Hospital of Mexico City; Mrs. Guadalupe Zuñiga de González, one of the three judges of the Juvenile Court of the Federal District of Mexico; and two social workers, Señora de Ortega, of the staff of the new General Maximino Avila Camacho Maternal and Child Health and Welfare Center in Mexico City, and Señorita Guillermina Rodriguez, chief case worker in Dr. Martínez' Bureau, who had had previous experience in Ciudad Juárez, across the Rio Grande from El Paso, first as a school teacher and as organizer of the first school-lunch program in that city.

The State health officers of all of the Mexican border States were present, as well as most of the directors of State maternal and child-health divisions, including Dr. Alfonso Gaitan Alcántara of Mexicali, Lower California, who was recommended by members of the round table for designation as Secretary of the Maternal and Child Health and Welfare Section.

Photograph by National Housing Agency

MATERNAL and child health now has a permanent place on the agenda of the U. S.-Mexico Border Public Health Association, which meets annually.

Among those in attendance from the United States side of the border were: Dr. Hilda H. Kroeger, Director of the Division of Maternal and Child Health, State Department of Health of Arizona; Dr. Marion Hotopp, who occupies the same position in New Mexico; Dr. José Olea, representing Dr. Lewis Robbins of the City Health Department of San Antonio, Texas; Lydia H. Cage, representing Mr. Howard Lackey of the Division of Child Welfare, Texas State Department of Public Welfare; Ann M. Bracken, Director of Child Welfare Division of the State of Arizona; and regional consultants of the Children's Bureau, representing maternal- and child-health and crippled children's services, child-welfare services, and child-labor law administration.

FAUSTINO ESPINOZ
CHIHUAHUA ST 113
MUSICO

Photograph by National Housing Agency

FAMILIES like this one will benefit through the cooperative activities of health authorities on both sides of the United States-Mexico border.

Each of the round tables held two sessions, one in El Paso and the other in Ciudad Juárez. The first meeting of the round table on maternal and child health and welfare was devoted to presentation and discussion of a paper prepared especially for the conference by Dr. Leopoldo Chávez, including a compilation of the social legislation in the Mexican border States, describing the major underlying causes of juvenile delinquency and concluding with recommendations for action by appropriate authorities along the border. Dr. Chávez' recommendations formed the basis for discussion and for formulation of definite proposals, which were included in the report of the round table.

The second session opened with presentation of a paper on the midwife program in New Mexico by Frances Fell, public-health nurse-midwife consultant, of the department of public health in Santa Fe, which was likewise the subject of animated discussion leading to concrete recommendations. At this session, Dr. José Olea also gave an interesting follow-up report of the campaign for control of infantile diarrhea in San Antonio, which he first described last year.

When Mr. Ehlers in his presidential address described the various public-health programs in operation along the border, it was obvious that many of these helped to promote maternal and child health and welfare directly and indirectly. For instance, sanitary engineers have converted a former dump into a park-playground; programs for the control of venereal diseases, tuberculosis, and communicable diseases, including infantile paralysis, bear a close relationship to the health of mothers and children.

The dedication of a new health center at Ciudad Juárez by Dr. Gustavo Baz, Secretary of Public Health and Welfare of Mexico, was one of the high-lights of the meeting. The beautiful building of Mexican colonial architecture in which the health center is located housed all of the round tables on the second day of the conference.

The pressure of 3 days of intensive work was broken by formal and informal functions, including the President's banquet in El Paso, where Dr. James R. Scott of the State Department of Public Health of Santa Fe, New Mexico, served as master of ceremonies. Dr. Scott was nominated as President-elect of the association. Following the dedication ceremony of the new Juárez Health Center, the delegates were guests at a reception offered by the Chief of Party of the Institute of Inter-American Affairs of Mexico City. Dr. Opal Cameron Hartline, director of health education of the El Paso City-County Health Department, presided at a luncheon for women members of the association. Dr. Hartline was also in charge of the exhibits, which were a feature of the Conference. Speakers at the women's luncheon included Dr. Hilda H. Kroeger, who told of "Cooperation Between Agencies" in Arizona, and Mrs. Elisabeth Shirley Enochs, who spoke on "Women's Contributions to Maternal and Child Health in the Americas."

At the banquet for the President-elect, held in Ciudad, Juárez, Mexico, addresses were made by Colonel George B. L. Reyer, commanding officer of the William Beaumont General Hospital; Dr. Pedro Daniel Martínez, Director General of Child Health and Welfare of Mexico; and Mrs. Enochs of the Children's Bureau. The guests were introduced by Dr. Angel de la Garza Brito, Director of the School of Hygiene of Mexico. The introduction of Dr. James A. Grider, Jr., who had played an important part in organizing the Conference, after his return from a Japanese prison camp, brought an ovation for this hero of Bataan.

Recommendations

The following are the recommendations of the round table on maternal and child health and welfare, as approved by the Border Health Conference at its final session.

1. The provisional section on maternal and child health and

welfare suggests that in view of the importance of the problems within its field of competence it be incorporated in definitive form in the statutes of the United States-Mexico Border Public Health Association.

2. The function of the section should be to improve the following along the border:

a. Maternal and child health.

b. Social assistance of mothers and children.

c. Services of social prevention.

3. It is suggested that the co-chairmen of the section should be representatives of the Children's Bureau of the United States Department of Labor and of the Dirección General de Higiene y Asistencia Infantil de la Secretaría de Salubridad y Asistencia of Mexico, D. F., and that Dr. Alfonso Gaitan Alcántara, director of the maternal and child-health center in Mexicali, Lower California, be appointed as secretary.

4. In order to facilitate work along the border, the section recommends that local committees be set up, representing at least officials in the fields of public health and welfare, immigration, education, and labor. The names of the persons nominated by the appropriate authorities for membership would be submitted to the Association for approval.

5. The Association is requested to authorize these local committees to seek the cooperation of appropriate agencies in solving their problems.

6. It is proposed that the Association promote the exchange between the two countries of technical personnel, informational and educational material, and plans of work, and the preparation of a directory of public and private maternal and child health and welfare agencies in the border States.

7. It is recommended that the training of untrained midwives be promoted and that fellowships be made available for training and refresher courses for graduate nurse-midwives.

8. It is recommended that at the next meeting the section devote special attention to the subject of nutrition.

IN THE NEWS

New Spanish Translations of C. B. Publications

New translations into Spanish have been made of three Children's Bureau publications, "Prenatal Care," "Infant Care," and "Your Child From One to Six." The translating was done by the American International Institute for the Protection of Childhood, Montevideo, Uruguay. The Spanish editions of the three publications will be distributed by the Department of State through United States diplomatic missions in Spanish-speaking countries.

Earlier editions of these three publications were translated some years ago by the Central Translating Division of the United States Department of State and were distributed by that department through the diplomatic missions. So many copies of these translations were needed that the plates from which the printing was done became worn out and eventually had to be destroyed.

Dr. Guillermo Morales Beltrami, Director of the National Bureau for the Protection of Childhood and Adolescence, Ministry of Health, Chile, thereupon made the suggestion that the Institute make a new translation, with special attention to the vocabularies used in the different Spanish-speaking countries.

Marian M. Crane, M. D. of the staff of the Children's Bureau, and Dr. Albert B. Franklin, cultural-relations attache of the United States Department of State in Montevideo, consulted with Dr. Roberto Berro, director of the Institute and his associates, Dr. Víctor Escardó and Professor Emilie Fournié, with regard to plans for the translations.

In an effort to avoid the confusion that might result from the fact that different countries use different terms for the same idea, the translations have been reviewed by the technical delegates of several member countries of the Institute. The terms used in the largest number of countries are used in the translations; the others are given in a glossary in each publication.

Union Adopts Resolutions on Child Labor and Child Care

The United Auto Workers, CIO, at Atlantic City, March 23–29, 1946, stated that it opposes employment of children and young people at too early age and under harmful conditions that deprive them of their full chance for an education and for normal growth, and adopted a resolution supporting the principle of a 16-year minimum age in State laws for all employment during school hours and for employment at any time in manufacturing and mechanical establishments and urging its members and locals to work for the enactment of such legislation.

Another resolution adopted by the union called for Federal and State programs to provide (a) student aid for boys and girls who would otherwise have to go to work, to help them complete their schooling, and (b) good counseling and vocational-guidance services to help young people to make wise decisions on training and jobs.

That necessary welfare services should be within reach of all children who need them was urged in another resolution. As part of such welfare services, the resolution named "day care for children of working mothers, recreational and other services that will cut down on juvenile delinquency, and care for dependent and neglected children."

The union also resolved to "work to make nursery schools a permanent part of our school structure, free to all parents in the community wishing to avail themselves of the opportunity."

EPILEPTIC CHILD CAN LEAD NORMAL LIFE

Large proportion of children with seizures can be helped toward goal of physical and mental health

by HARRY SANDS, Administrator and Psychologist
Baird Foundation Clinic, National Association to Control Epilepsy

● Epilepsy is not a rare disease which affects relatively few people. Recent estimates suggest, on the contrary, that between 500,000 and 700,000 persons, of both sexes, in the United States are epileptic, many of them adolescents and younger children. Selective Service reports that among more than 9,000,000 men from 18 to 44 years of age in this country who received physical examinations through selective-service boards from April 1942 to December 1943, 5 of each thousand, or 45,000 men, were rejected because they were diagnosed as having epilepsy. In addition, recent statements from the Army and Navy have shown that for every thousand men in all the armed services, between 1.0 and 1.5 cases of epilepsy were diagnosed. In fact it can be safely said that the incidence of this disorder equals that of diabetes or of active tuberculosis.

It is extremely important that we accept the continually accumulating evidence that persons with epileptic seizures are intellectually and emotionally normal, rather than to adhere to the archaic belief that such persons are feebleminded or psychotic. The latter notion was understandable when it was held by the ancients centuries ago, but it has no place in an enlightened society. It is unfortunately true, however, that even today there are large numbers of people who stand in awe of this ailment. Some actually believe that it is communicable, although medical science has shown that it is not. Many parents are ashamed to have it known that their children have epilepsy. The existence of these unjust attitudes points to the fact that people who are in general well informed should do what they can to obtain and disseminate the latest and soundest knowledge about epilepsy.

No precise figures are available on the number of children who are subject to seizures. We know, however, that approximately 80 percent of all cases of epilepsy have their onset in persons below the age of 20.

Epileptics can work successfully

It is estimated that one-tenth of the epileptics in the country are in institutions, at an annual cost to the public of $20,000,000. Many who remain in the community are self-sufficient, but others cause a loss to the Nation at large because, though the majority are able to work successfully, many cannot get jobs, for employers are reluctant to hire them.

The professional people who are concerned with the health of the Nation have done much to control epilepsy, although as yet they have not found a cure. Their efforts have been coupled with those of national nonmedical organizations, such as the National Association to Control Epilepsy, New York City, and the American Epilepsy League, Boston, which have worked to make the problem clear to the public.

How parents react

Many parents of epileptic children show good sense in their approach to the problem, although some need guidance.

Other parents show a bewildered "Why-did-this have-to-happen-to-me?" attitude. Their immediate plan consists of placing the child in an institution or in a foster home. And this in spite of the fact that to the average understanding parent many of these children would not present any extraordinary problems in their development. It is no wonder that these children develop skewed personalities.

Some parents go to the other extreme of taking an overprotective attitude toward the child, coddling him and shielding him from all his normal responsibilities to himself and to others about him. The social vacuum in which such a child grows up accounts for his continuing to have immature characteristics right through childhood and adulthood.

It is after the child's seizures are brought medically under control that his immaturity is first noticed, and then the parents complain that the child does not get along with playmates of his own age and that he does not carry out the social duties expected of him.

School problems like those at home

The problems confronting epileptic children in school are to a marked degree similar to the problems they face in their homes. Often the knowledge on the part of school authorities that a child has been diagnosed as epileptic—even if he has not experienced any seizures in school—is sufficient to have him dropped from the school rolls or at least placed unnecessarily in a special class. If he stays in his regular class, his teacher may be indifferent to his progress because she does not know how to cope with what seems to her too difficult a situation. An additional trouble that may face the child is this: If he fails in any school subject, the teacher may attribute this to the fact that he is an epileptic, not realizing that his failure may be caused by the same factors that cause other children in the class to fail.

An excellent example of a successful approach to the child with epilepsy is found at the White Special School, which is an integral part of the Detroit public-school system. This special school was organized specifically to help epileptic children to attain complete orientation. Here the epileptic pupil follows the usual elementary-school or high-school curriculum. The school physician brings the seizures under control through adequate medication. The teachers have a thorough knowledge of the child's needs, and they help him to gain an understanding of his ailment and an insight into the manner in which people will probably respond to him. As soon as a child has accomplished this understanding, he is returned to his regular school, where he functions on the same level as the rest of the pupils in his own grade.

Understanding adult needed

Recreation for epileptic children is of course an important factor in their personality development, just as it is for other handicapped children, and for all children. At the school or neighborhood playground a child with epilepsy may take part successfully in the usual activities, but only if an adult play leader understands the disease. A leader with this knowledge knows there is nothing for her or the group of children to be afraid of when a child has a seizure. The leader who thus understands the situation will be able to convey her calm, casual attitude to the children. This kind of leadership is necessary also when epileptic children go to community camps. As yet camps have limited experience in accepting such children. But now more and more camps are working toward inclusion of epileptics as well as other physically handicapped children.

Some behavior problems disappear

Some of the behavior in a person afflicted with epilepsy seems to be due to disturbances in the chemical and electrical reactions in the brain cells, for often, with treatment by drugs, some behavior symtoms disappear immediately. But the attitudes an epileptic has are not caused by the disease itself; they are a reflection of the attitude of other people toward him. There is rather good scientific evidence that the term "epileptic personality" is not really a result of epilepsy per se. That is, the personality of a child with epilepsy is not the result of his seizures. On the contrary, his personality, like that of any other child, will or will not be wholesome, depending upon how his parents, family, playmates, teachers, and others accept him as an individual. That is, whether they like him and treat him as an equal in an emotional sense, or whether they are frightened of him, and he of them; in other words, whether he is made to feel he is different—an outcast—from the rest of the people he lives, plays, and eats with.

Intelligence tests given to a random sample of persons with epilepsy show that at one extreme they are very bright (even in the genius class), and at the other extreme very dull; the largest number are in the "average" group. It cannot be overstressed that the epileptic population seems to show the same frequency distribution in relation to intelligence as does any random sample of "normal" individuals. When other objective psychological tests are given to epileptic children the results do not as a rule show any significant differences from the results of tests given to nonepileptic children. When the data show differences from data on "normal" children it is only when the epileptics are in institutions or are in other nonrepresentative groups. It is no more correct to generalize about an epileptic child living in his community from data on epileptic children in institutions than to generalize about any other child residing in a community by comparing him with children in institutions.

It may be in place to mention at this point that some of the false ideas outlined above, when they are viewed in the light of current scientific knowledge, seem even more incongruous with the facts. When the anticonvulsant medicines in present use, such as dilantin, glutamic acid, hydantoin, and tridione, are administered judiciously they are instrumental in effecting complete control of the seizures—or even the elimination of them—in nearly 50 percent of the cases, and in reducing the frequency or intensity of the seizures in an additional 20 to 30 percent. Thus, from 70 to 80 percent of persons with epilepsy so treated can be regarded as potentially contributing members of society, and they can be helped toward attaining the goal of physical and mental health.

It must be remembered, of course, that there still remain a number of children whose condition does not respond to treatment as does that of the average epileptic child. This 20 or 30 percent must at present remain a problem for medical and other care.

Work of Baird Foundation Clinic

Through the work of an integrated team of professional workers similar to those found at most child-guidance centers in this country, a coordinated approach to the treatment and guidance of children with seizures is made possible at the Baird Foundation Clinic, which was established in an effort to build up the public's knowledge of epilepsy, while working to benefit children with the disease. This clinic was founded by the Association to Control Epilepsy, through a grant from a foundation, the David, Josephine, and Winfield Baird Foundation. It is located in New York City.

The neurologist on this team, in addition to confirming the diagnosis of epilepsy, undertakes to bring the seizures under control by means of proven anticonvulsant medicines and to give the prognosis of the seizures.

It is within the province of the clinic psychiatrist to rule out the cases that are not amenable to treatment within the scope of the clinic. When however, psychiatric treatment is needed, he outlines the course to be followed. He also supervises the psychotherapy given by other members of the staff.

When pediatric consultation is needed for some special problem a pediatrician is called in. (The clinic recognizes the need for a full-time pediatrician, but budgetary limitations have so far made this impossible.)

Through the use of standard objective tests, the psychologist outlines the child's capacities, abilities, educational achievements, and personality endowment. This makes it possible to know whether or not the child is functioning at a level in keeping with his capacities.

The child's attitude toward himself and others with whom he comes in contact is studied at the clinic. If a specific problem is indicated, an appropriate course is followed through interviews and through therapies involving play, art, and music.

The social worker gathers the components of a complete picture of the child's home, school, and community environments, and plans a program to meet his needs in each of these.

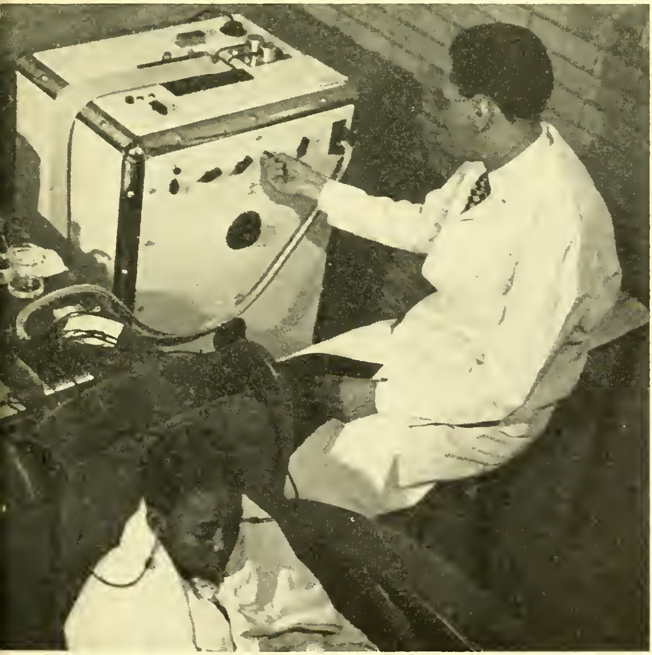
When all the findings are brought together they are discussed at case conferences with a view of working out the best possible over-all regime for the child.

Besides working with the children, the professional workers at the clinic hold periodic meetings with groups of parents to discuss the problems of epilepsy in children. The staff members make public appearances, giving lectures and taking part in educational forums, and conduct research projects that are reported in scientific literature and described before professional groups. They also act as consultants to social and governmental agencies concerned with the disease, and to industry, and integrate their work with national organizations that combat the problems of epilepsy.

The pivotal point upon which the Baird Foundation Clinic functions is that the epileptic child needs to be treated not only by medical measures, but also *far beyond medication* if his essential social needs are to be fulfilled effectively. To help parents accept this challenge, the clinic tries to give them not only an understanding of epilepsy as a physical disorder but also a knowledge of what determines the general behavior of their children. Furthermore, they are instructed how to help direct community opinion away from the prevalent misconceptions concerning epilepsy.

BRAIN-WAVE PATTERNS can be recorded by a device called an electroencephalograph; tendencies toward epilepsy may be revealed by these patterns. The doctor is getting ready to record Robert's pattern. (When the record of the brain waves was examined it showed no tendency toward epilepsy.)

Photograph by Philip Bonn, for Children's Bureau



To this end, the clinic also fosters a better comprehension of the epileptic child by the schools so that he will have the benefits of a regular education and thus be in a position to compete on an equal plane with other children and later on with adults. To serve this purpose, the clinic places at the disposal of each child's teacher the objectively derived data on the child, including a description of his seizures and information on what to do about them, a picture of his abilities and his disabilities, and other facts, all adding up to form a clear, composite picture of the child.

In much the same manner, persons in the community with whom the child comes into contact in daily life are given pertinent information about him so that they can help resolve his problems instead of acting so as to re-create them. The cardinal principle continually stressed at the Baird Foundation Clinic is that everything must be done for the epileptic child to prevent personality malformations and thus to assure him his rightful place among his fellows.

People who wish to know more about epilepsy may be interested in the following:

Epilepsy; The Ghost is Out of the Closet, by Herbert Yahraes. Public Affairs Pamphlet No. 98, Public Affairs Committee, 30 Rockefeller Plaza, New York 20, N. Y., 1944. 31 pp. 10 cents.

Convulsive Seizures; How to deal with them, by Tracy Putnam, M. D. J. B. Lippincott Co., Philadelphia, 1945. 2d ed. 160 pp.

Science and Seizures; New light on epilepsy and migraine, by William G. Lennox, M. D. Harper & Bros., New York, 1945. 2d ed. 258 pp.

CANADIAN COMMISSION STUDIES YOUTH

Comprehensive survey looks toward better opportunity for young people

by HOPE CASTAGNOLA

Industrial Division
U. S. Children's Bureau

● For the past 3 years the Canadian Youth Commission has been working to help Canadian young people to get the opportunity they need. The commission, a private organization financed by donations from public-spirited citizens, is a group of men and women chosen for their interest in young people and their experience in working with them. The members are from all parts of Canada. They include French and English; Roman Catholic, Protestant, and Jewish; and representatives of labor, industry, and agriculture, and of the armed services. The chairman is Dr. Sidney E. Smith, president of the University of Toronto. The director is R. E. G. Davis.

The commission was established in April 1943 to study problems of young people between the ages of 15 and 24, to draft reports and recommendations based on its studies, and to promote the acceptance of these recommendations by Government and private agencies.

The commission found that it could best study the main problems of youth under seven separate headings — education, employment, citizenship, health, family living, recreation, religion, and life philosophy.

About 1,000 persons—professional workers and laymen—cooperated with the commission in an effort to analyze youth's problems.

National youth-opinion survey

The opinions of youth were sought. Provincial committees were established in every Province to organize study groups of young people. Thousands of young people met, in these groups or in mass conferences, to debate, to pool ideas, and to seek common ground. Eight hundred reports of their conference decisions were sent to the commission.

A national youth-opinion survey was conducted for the commission by means of well-worked-out sampling procedures; these provided a means of obtaining answers to specific questions.

Sampling of many groups

For collection of more personal information, the commission undertook interviews, also on a sample basis, with young people of many economic, social, and religious groups.

Two of the commission's reports that have already been published are "Youth and Jobs in Canada" and "Youth Challenges the Educators." Among other subjects on which the commission is reporting are religion, youth organizations, recreation, and health. The reports include the opinion of youth, along with those of experts, and in each report the commission gives its conclusions and recommendations.

In "Youth and Jobs in Canada," the young people are reported as almost invariably naming as the fundamental necessity the prospect of employment. They say, in effect, "Give us jobs with reasonable standards and permanence and everything else will be possible."

Some of their proposals are concerned with raising the school-leaving age and providing vocational guidance and training and also employment services.

In its recommendations on youth employment, the commission calls upon Canada's Federal and Provincial Governments to accept as a major responsibility the maintenance of full employment and urges the necessity for the Federal Government to pursue a continuing policy of economic collaboration with other nations.

Public-works programs will be essential, the commission recognizes, in order to insure full employment during the period of reconversion. It suggests that youth-work programs be set up under Government auspices for youth 16 to 21 years of age who would otherwise be out of school and unemployed. These programs, on a voluntary basis, should provide work of various kinds for which wages would be paid, says the report, and should include physical, vocational, and citizenship training. The majority of the commission is opposed to the idea of a compulsory year of national work service.

Recommendations on placement

The Dominion Employment Service, the report goes on to say, should be the major agency for relocating workers after the war and for coordinating efforts in the whole field of placement. Two improvements with reference to youth are recommended: (1) That special departments for youth under 21 should be established in all local offices and should cooperate with juvenile advisory employment committees of carefully selected local citizens; (2) that reliable information on job opportunities for youth and on youth unemployment should be compiled and distributed regularly. The Dominion Service's counseling work should be supplemented, on the basis of a carefully developed plan, by the service of schools, youth organizations, and social-service agencies in the local communities.

Extending and strengthening child-labor legislation is urged. The standards of the International Labor Conventions are viewed as a necessary minimum, with higher standards to be established as quickly as practicable. A minimum age of 16 years is recommended for industrial and nonindustrial employment, and of 18 years for hazardous employment. For street trading and for work in

Photograph lent by Canadian Embassy

THINKING AHEAD for Canada's 3 million youngsters, like these who are under 15, and for 2 million young people who are 15 to 24, the Canadian Youth Commission calls for a broad expansion in educational opportunities for them.

public places such as bowling alleys, theaters, hotels, and restaurants, a minimum age of 17 years is recommended, and for employment in agriculture a minimum of 15 years, with an annual school attendance of at least 8 months. The commission further recommends that employment of persons under 18 years be prohibited for more than 36 hours per week and 8 hours per day; that 24 days of vacation with pay be given annually to employees under 18; that the individual employer be liable for double compensation for persons illegally employed; and that free medical examinations be provided for all young persons before their initial employment.

In "Youth Challenges the Educators" the commission presents the opinions of the young people with regard to their school conditions. "Contrary to much that everyday discussion and comment would lead one to believe," the report says, "the teacher as such is not the center and source of all the frictions, discomforts, and maladjustments suffered by young people as they pass through school." In fact, of the 1,467 young Canadians who were given this "attractive opportunity to unburden their souls about the defects of the schools," less than 4 percent indicated any dissatisfaction with their teachers. What the majority did urge was that the schools should be closer to the working world, closer to the world of conflicting political, economic, and social forces, and that the school should prepare pupils for graceful participation in social living.

After presenting the ideas of the young people the commission lists some recommendations agreed upon by educational groups; for example, that the best educational facilities that the most favored communities in Canada have should be extended to all Canadians; that more attention should be paid to the health of the children; that curricula must be so diversified as to meet the needs of all children to the fullest possible extent, to the end that each child may be fitted to make his maximum contribution to society; and that the schools should be better housed.

Furthermore, the recommendations urge that the entire school program should be integrated with the life of the community; that to give effect to the reforms much more money should be made available; and that the Federal Government should share in the provision of these much-needed funds.

Summing up, the commission says that there is great need in Canada to realize that education is a lifelong process which begins long before the child ever sees a school and which is a necessary part of the life of adult citizens of all ages.

Urging development of programs for adult education, the commission recommends that technical and community institutes be established to serve young people not intending to go to a university; also evening classes should be provided, along with informal discussion groups and the development of handicrafts for hobbies and self-expression. Part-time education of youth engaged in industry, according to the commission, should be seriously considered.

Reports of the commission which have been published or are expected to be published soon may be obtained from the Ryerson Press, Toronto, Canada. They are: Youth and Jobs in Canada, $1.25; Young Canada and Religion, $1; Youth Challenges the Educators, $1; Youth Organizations in Canada, $1.50; Youth and Recreation, $1.25; Youth and Health, $1.

The Canadian Youth Commission has clearly made a great contribution to the people of Canada who desire to see that the youth of their country have broader opportunities in the future. The commission's report can also afford stimulus and help to the many groups and individuals in the United States that see an urgent need for increasing the employment and educational opportunities of their own young people.

I. L. O. HOLDS REGIONAL CONFERENCE IN MEXICO CITY

by BEATRICE McCONNELL

Director, Industrial Division
U. S. Children's Bureau

● The third regional conference of the countries in the Western Hemisphere that are members of the International Labor Organization met in Mexico City, April 1 through 16, 1946. The Americas were represented by delegations from 16 countries and by official observers from 4.

The Government delegates from the United States to the Conference were Dennis Chavez, United States Senator from New Mexico, and Verne A. Zimmer, director of the U. S. Department of Labor's Division of Labor Standards. The employers' delegate was David Zellerbach, and the workers' delegate, George Meany, secretary-treasurer of the American Federation of Labor. A full delegation consists of two Government delegates, one employers' delegate, and one workers'. (Beatrice McConnell attended the conference as technical adviser to the United States delegation.)

The importance—and necessity—of industrialization of Latin America as a means of effectually utilizing its natural resources and improving its standard of living and its general prosperity was a common thread that ran through the conference discussions—not only of the general problems but of the technical ones as well.

Three technical subjects taken up

Besides the broad problems of special concern to Latin America that were described in the I. L. O. Director's report as a basis for discussion—industrialization, inflation, migration from Europe, social security, and indigenous populations—the conference took up three technical subjects, vocational training, industrial relations, and labor inspection, and appointed a committee to consider each of these.

The vocational-training committee emphasized the importance of expanded and improved vocational-training programs as a practical means of helping to assure educational and vocational equality among the nations and as a step that is necessary for the desired expansion of industry and trade in the Latin American countries. The committee emphasized the importance of vocational guidance to enable youth to make wise choices as to training opportunities, and called attention to the necessity for qualified and trained staff. Particular attention needs to be paid to the vocational problems of special groups, the committee reported, such as the problems of the physically handicapped and of members of certain indigenous groups. Strong interest was expressed in the development of better regional cooperation in matters relating to vocational-training programs; also in the desirability not only of exchange of information on this subject between the countries of the Americas, but also of exchange of trainees and apprentices.

The committee on vocational training laid particular stress on the social and economic objectives of a vocational-training program in providing opportunities for developing the full capacities of youth, in meeting labor needs, and in promoting general well-being by developing human and material resources with a view to raising living standards.

The conclusions of the committee on labor inspection were incorporated in a resolution dealing, among other matters, with administrative organization, the nature and scope of an inspector's duties, and qualifications of inspectors.

Some of the other resolutions adopted were on industrial relations, industrialization, inflation, and improvement and standardization of labor statistics.

Opportunity for exchange of experience

This Mexico City Conference, the first opportunity for this kind of exchange of experience and of problems since the close of World War II, gave an opportunity for the American States, as Mr. Edward J. Phelan, acting director of the I. L. O. and Secretary General of the Conference, expressed it, to take their bearings and set their course. "The need of the world," he said further, "is not only for machinery through which its problems may be examined. What is even more important is the spirit in which the solution of those problems must be sought, and no conference better than a conference of the American States can set an example of how the principles of universality and the needs of regional application can be reconciled in a due equilibrium inspired by the fundamental considerations of freedom, democracy, humanity, and progress." After recalling prior conferences of the American States, Mr. Phelan pointed out that "those earlier meetings were in the nature of experiments. The present meeting * * * derives not only from those earlier meetings but also from the general principles of the Declaration of Philadelphia and from the necessity for their practical realization in all the great regions of the world. It not only consolidates a new instrument of social progress for the Americas, but it will fashion and perfect the principles on which similar conferences will be organized by the International Labor Organization for other regions whose problems call for urgent attention." (Director's Report. International Labor Office, Montreal, 1946.)

CHILDREN AROUND THE WORLD

MEXICO

First National Congress of Health and Welfare

The First National Congress of Health and Welfare of Mexico will meet in Mexico City from August 25 to August 31, 1946. The Congress, which will be held under the auspices of the Federal Department of Health and Welfare, will be open to delegates of Government agencies and of private organizations.

Such subjects as Federal and State legislation on health and welfare, organization of the health and welfare services for mothers and children, medical care and social welfare for the people as a whole, health education, and training of personnel are on the agenda.

Source: *Primer Congreso Nacional de Salubridad y Asistencia; Convocatoria, Reglamento, Programa, Temario. México, D. F., 1946.*

ARGENTINA

School of Child Care, Cordova

The School of Child Care (Escuela de Puericultura) of Cordova, Argentina, the first of its kind in that country, was established in 1943 in the Division of Mothers and Children of the National Bureau of Public Health. The main purpose of the school is prevention of disease among children.

The report of the school for 1945 groups its activities into four main categories.

Health education and social services make up the first category. Health-education leaflets on prenatal care, infant care, care of the teeth, and other subjects are distributed by women health visitors who go to the homes and supplement the printed information with oral instruction. Lectures are given for mothers, and information on health is made available also through the radio, motion pictures, and the press. Among the social services the report mentions placement of children in foster homes, measures to bring about legitimation of children born out of wedlock, finding of employment for fathers, and provision of hospital care for mothers and children for whose treatment the school has no facilities.

The second category of the school's activities is concerned mainly with immunization against certain communicable diseases and treatment of syphilis. Children who attend the various clinics of the school are immunized against diphtheria, smallpox, typhoid fever, and whooping cough. The importance of immunization is explained by the health visitors in the people's homes and in schools.

Tuberculin tests and vaccinations against tuberculosis are also given to the children. An important part of the school's work is treatment of syphilis in the mothers and children receiving services from the school and in other members of their families.

For prevention of deficiency diseases, vitamins and certain auxiliary foods are distributed; the quantities of the latter are said to be limited because of insufficient resources.

Measures are also taken for the prevention of gastrointestinal disorders which are frequent in the summer.

At a mental-hygiene clinic directed by a psychiatrist treatment is given for the prevention or correction of nervous and mental diseases in children.

The third phase of the school's work relates to the sick child. At a general out-patient clinic for babies, children of preschool age, and school children, medical, surgical, and dental treatment is given. A laboratory and an X-ray clinic are maintained. Medical records of all patients are kept. A small hospital is maintained for premature babies and other babies needing hospital care.

The last category of the school's work includes the training of personnel. Already a nurses' training school has been opened. Also plans have been made for organizing courses in child care and child nutrition for physicians, medical students, and nurses.

Source: *Escuela de Puericultura, Cordoba, Memoria, 1945 (manuscript).*

A. K. S.

BRAZIL

New Director of National Children's Bureau

Appointment of Dr. Milton Carlos Braga Neto, pediatrician, as director of the National Children's Bureau of Brazil has been recently announced. The new director replaces Professor Olinto de Oliveira, the first director of the National Children's Bureau, who has retired because of age. The Bureau has been administering child health and welfare work in Brazil since 1940.

CHILE

Recommendations for the Improvement of the Situation of Mothers and Children

Appointment of a committee of the Chilean Senate to study means of improving the situation of mothers and children in that country is recommended by Senator Salvador Allende, a former Minister of Public Health, who is the author of a book on medical and social problems in Chile. Senator Allende also recommends the organization of a single Government agency to deal with all problems concerning expectant mothers and problems concerning children up to the age of 16 years.

WEST INDIES

Conference Adopts Recommendations for Benefit of Children

The West Indian Conference, which met February 21, 1946, for the second time, attended by representatives of Barbados, Curacao, Martinique, Puerto Rico, Surinam, Windward Islands, and the United States, adopted a committee report recommending a number of measures for the benefit of children. One of these recommendations urges the "immediate setting up within the area of basic norms of social legislation on such matters as workmen's compensation, social security, child labor, and the like." Another recommendation, on health education, includes maternity and child welfare among the problems that need special attention.

The recommendations on nutrition include the following:

That it should be the objective of every educational authority ultimately to provide a well-balanced school meal each day to every child in school. The nature of the meal provided and methods of cooking and serving should be such that children will develop tastes for varieties of properly balanced diets.

That the proper feeding of children of preschool age and children of school age who are not in school, as well as expectant and lactating mothers, be at least as important as the feeding of school children, and as far as practicable, the territories provide adequate diets for those who need it. We consider provision for adequate diets to be at least as important as provision for education.

That surveys be made to determine the nutritional needs of all children whether in school or not.

That measures be taken to ensure that the food supplies available be used to the best advantage, by teaching improved methods of cooking, the balancing of diets, and the preserving and storage of surplus food products.

That studies be made of the cheaper sources of the main ingredients that are deficient in the diets of the area and of methods by which they may be embodied in attractive menus. (We wish to call attention to the investigations which at present time are being carried out in Puerto Rico on cheap supplementary proteins of high nutritive value.) That in this program there be no social discrimination against any group of children; that responsibility by parents and communities be encouraged.

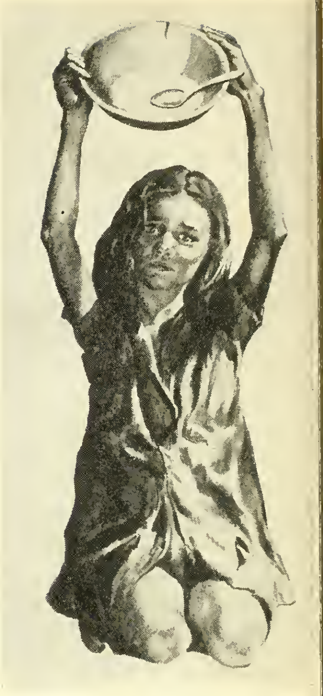
American Youth for World Youth

American Youth for World Youth is now the name of the organization formerly called American Youth for European Youth. The new name indicates the greater scope of the work of the organization, which is now developing programs in India, China, and the Philippines, in addition to those already operating in Europe.

The primary objective of this organization is to encourage the youth of the United States to establish friendly personal relations with children in other countries and thereby promote active international good will and help establish a foundation for permanent friendly international relations. Wherever these foreign friends are in need, American youth will help, says the organization's statement of policy. Not merely by letter writing or even by a gracious bestowing of gifts; only by doing, by working for and sharing with these overseas friends, can this comradely relationship be established, the statement continues. Not by collecting from parents and others but by the work of their own hands can young Americans best express and realize their will to help. It is an essential part of the program that it be planned, organized, and executed by the youth themselves.

An advisory board of educators and child-welfare specialists counsels the executive committee of the organization, the staff, and committees of the youth groups participating in the program.

Schools and youth groups promoting this program make the necessary contacts and send their gifts through the office of American Youth for World Youth, 35 East 35th Street, New York 16, N. Y. This office works through the member agencies of the American Council of Voluntary Agencies for Foreign Service or deals directly with overseas educational and child-welfare authorities.



THIS APPEAL FOR FOOD is the symbol adopted by President Truman's Famine Emergency Committee in the campaign to alleviate suffering in war-stricken countries in Europe and Asia.

Show These Two Films in Your Community

"Freedom and Famine" and "Suffer Little Children" are two 16-millimeter sound films, which will help make people realize the plight of the starving children of Europe, who must be fed or left to die.

Both of these films have been produced by the United States Department of Agriculture for the President's Famine Emergency Committee. Each runs 10 minutes. The films can be borrowed from your State university film library, or from a local film distributor. Make your request as far in advance of showing as possible, and be sure to give the showing date or dates.

U. S GOVERNMENT PRINTING OFFICE: 1946

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Social Statistics

CHANGES IN VOLUME OF
HEALTH AND WELFARE SERVICES
1942–43

WITH A TABULATION FOR 1944

May 1946
Supplement to THE CHILD, [redacted]

UNITED STATES DEPARTMENT OF LABOR
L. B. Schwellenbach, Secretary

CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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This report is the final presentation by the Children's Bureau of data collected through the social-statistics project. The Bureau terminated its responsibility for the operation of the project on June 30, 1945, because of inability to obtain increased funds for strengthening and expanding the reporting program. The Children's Bureau will continue its interest in statistics on local child-health and child-welfare programs and will continue working with State agencies toward the development of programs of research and statistics on child health and child welfare, both local and State-wide. Community Chests and Councils, Inc. has now assumed responsibility for the operation of the social-statistics project and is providing national supervision to the local registration areas.

CHANGES IN VOLUME OF HEALTH AND WELFARE SERVICES
1942-43[1]

By the end of 1943 the United States had been an active participant in World War II for 2 years. The pattern of changes that took place in the provision of health and welfare services in our second war year may be observed in the data reported to the Children's Bureau by 43 large urban areas participating in the Bureau's social-statistics project.[2]

Reports are collected in this project for 21 types of service in the fields of child welfare, family welfare and relief, health, and group work, and for the social-service exchange. Table 1 shows the types of service in each field for which data are available and the number of areas and agencies reporting each type of service.[3]

The changes that took place in the volume of health and welfare services were directly related to the social and economic aspects of wartime conditions. By the end of 1943 the pattern of wartime economy had been fairly well established. Although industrial and economic activity continued to expand in that year, the rate of expansion was not so rapid as in the two previous years. The number of inductions into the armed forces was so great that the size of the labor force decreased somewhat despite the normal additions to it and the recruitment of housewives, school-age youth, and persons who had previously been considered unemployable. In December 1943 there were 51.0 million employed as compared with 52.2 million a year earlier. Income payments to in-

TABLE 1.—*Number of reporting areas and agencies, by selected types of service, 1943*

Type of service	Areas			Agencies reporting[1]
	Reporting service	Not reporting service	With no organized service	
Child welfare:				
Protective and foster care	33	10	---	537
Day-care services	32	8	3	283
Maternity-home care	37	2	4	78
Family welfare and relief:				
Family welfare and relief, private agencies	37	6	---	256
Public general relief	42	1	---	96
Special types of public assistance:				
Aid to dependent children	43	---	---	53
Old-age assistance	42	1	---	49
Aid to the blind	41	2	---	48
Service and relief to transients and travelers	34	4	5	44
Shelter care	31	8	4	120
Institutions for aged, chronically ill, and dependent adults	25	17	1	194
Legal aid	27	7	9	27
Health:				
Hospital in-patient service	31	12	---	465
Clinic, other than mental hygiene	37	6	---	407
Mental-hygiene clinic	25	10	8	44
Medical service in patient's home and in doctor's office	29	13	1	64
School health programs, medical	33	7	3	78
Public-health nursing	36	7	---	188
Medical-social service	23	9	11	118
Group work:				
Local group-work agencies	32	11	---	343
Local groups organized under national programs	35	8	---	105
Social-service exchange	40	3	---	42

[1] When a single agency in an area provides a separately organized service in two or more of the specified fields, it is counted in each field.

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[1] Report prepared by Joseph L. Zarefsky, Chief, Social Statistics Section, Division of Statistical Research.

[2] An analysis of the volume of health and welfare services provided during the first full year of United States participation in the war is presented in "Changes in Volume of Health and Welfare Services, 1940-42," by Joseph L. Zarefsky. Social Statistics, Supplement to *The Child*, October 1944. (Children's Bureau, U. S. Department of Labor, Washington.)

[3] The figures reported by each area for each type of service except group work represent at least 80 percent of the total volume of such service provided in the area. In the group-work field the minimum requirement is 70 percent of the service provided by private agencies; information on public recreation services is not obtained in this project. Many of the services reported by the areas are provided both to residents of the area and to nonresidents, who are not considered the responsibility of the local community. For these services, except hospital in-patient service and maternity-home care, the statistics reported are for services provided to residents only.

dividuals in 1943 totaled more than 142.2 billion dollars, a 22-percent increase over 1942. This wartime prosperity was accompanied by an increase in the birth rate from 20.9 per 1,000 population in 1942 to 21.5 in 1943—the highest rate since 1924.

The year 1943 also marked the discontinuance of some governmental assistance programs, which in previous years had been the mainstay of millions of families. Employment under the Work Projects Administration program, which had been tapering off officially since the beginning of the year, was terminated in June 1943. The National Youth Administration student-work program also was terminated in June 1943, the out-of-school work program having been discontinued in the previous year. Our civilian economy had rapidly become one of shortages, affecting not only industrial commodities and labor supply but the distribution of food and agricultural products as well. The United States Department of Agriculture ordered the suspension of the food-stamp program on March 1, 1943, and, by the end of June of that year, had discontinued the direct distribution of commodities.

SUMMARY OF CHANGES IN VOLUME OF SERVICES, 1942–43

The combined reports of the 43 urban areas show decreases in all but two of the selected types of service between 1942 and 1943 [4] (fig. 1). For the most part, the changes in the volume of services represent a continuation of the changes noted between 1940 and 1942. Important interarea variations in the pattern of change occurred, however, because of differences in the location of heightened industrial activities and in State and local organization for health and welfare services.

The most marked changes occurred in the field of family welfare and relief, in which both the sharpest increase and the sharpest decrease were reported. As would be expected, the programs in which the demand for service is most directly related to economic need—public general relief and shelter care—showed the sharpest declines from 1942. The programs for special types of public assistance—aid to dependent children, old-age assistance, and aid to the blind—also showed decreases. A relatively large decrease occurred in the number of families receiving aid to dependent children, the effect of a combination of factors—employment of mothers and older children (and, in many instances, of school-age children), allotments and allowances from servicemen, increased support from relatives, and so forth. In some States eligibility requirements for the special types of assistance were liberalized in view of the availability of funds. Assistance payments generally were raised to meet increases in the cost of living, to make up for budgetary deficiencies due to the termination of the food-stamp plan, and in some cases to meet a greater proportion of recipients' actual needs.

The greatest increase in the volume of service between 1942 and 1943 was reported by private family-welfare and relief agencies.[5] Although their programs of financial assistance contracted, the total number of cases served by these agencies increased as a result of the war-connected activities of American Red Cross chapters, such as case-work services to members of the armed forces and their families. With more people on the move than ever before, travelers'-aid programs expanded markedly.

The volume of all types of health service was smaller in 1943 than in 1942. The sharpest decline was reported for medical service in the patient's home or the doctor's office. The number of patient-days' care provided in general and special hospitals decreased slightly from the preceding year, but a greater number of patients were served. The increased ability of patients to pay for hospital care—because of improved economic conditions, expansion of insurance plans for the prepayment of the costs of such care, and the operation of the Emergency Maternity and Infant Care program—is reflected in the continued decrease in the number of free patient-days and in the proportion of in-patient care that was free.

Decreases were reported by both public and private agencies in the volume of protective and foster care of children. Foster-family care was the major type of service provided under public auspices. Foster-family care under public auspices represented more than half of all foster-family care provided in the reporting areas. The volume of day-care services increased markedly from 1942 as Federal funds under the Lanham Act became available to communities for the provision of such care.

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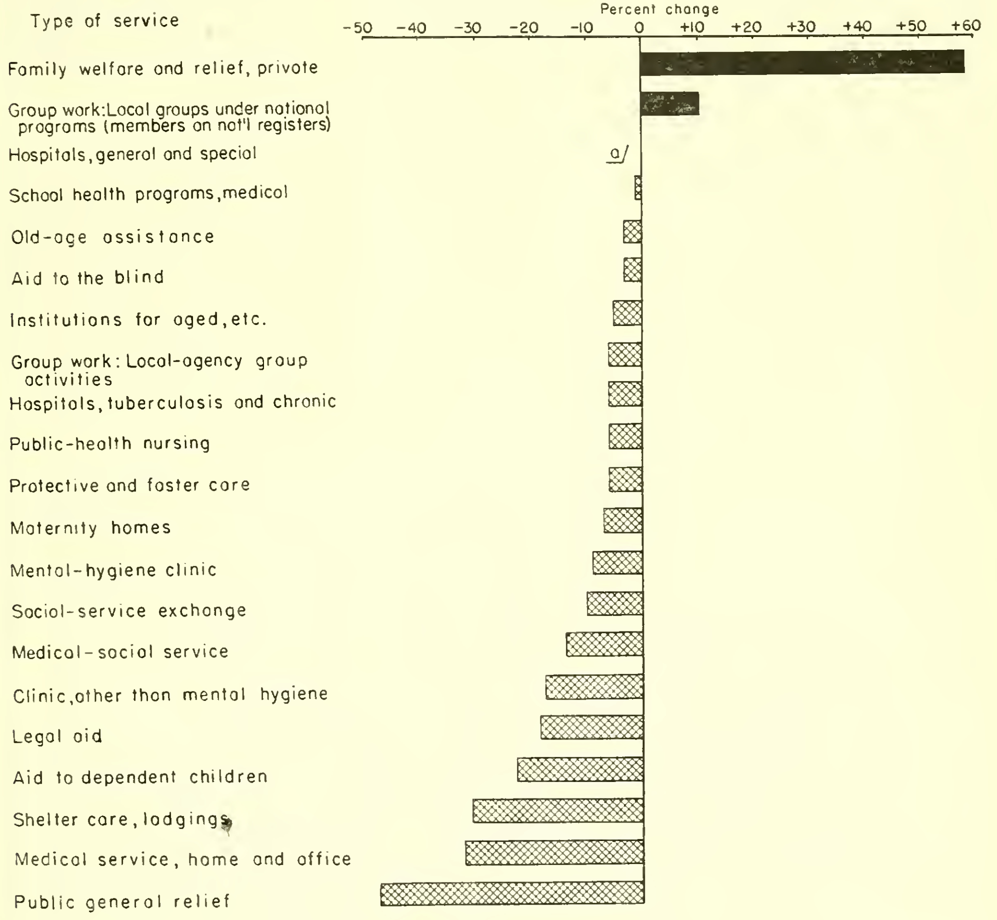
[4] The 1943 average monthly figures for each type of service as reported by each area are given in table 10; the percentage change from 1942 in each of these figures is given in table 11.

[5] In this report auspices are classified not by the source of the agency's funds but by the nature of the governing body responsible for policies and administration of the program. Private agencies are those that are operated by nonprofit associations and other voluntary groups; public agencies are those that are operated by local, State, or Federal governmental bodies.

Attendance at organized group activities conducted by local leisure-time agencies decreased, but membership in the national-program groups increased. The statistics reported do not include figures for most United Service Organization and allied activities, which are an important part of the leisure-time programs of many urban communities.

A review of the statistics for 1943 suggests that two important factors—improved economic conditions and reduced ability to provide service—were basic to the declines in service reported. Im-

FIGURE 1.—*Changes from 1942 to 1943 in average monthly figures for selected types of health and welfare service; 43 urban areas.*



a/ Decrease less than 0.5 percent

proved economic conditions lessened the need for some services, the demand for which is closely tied to economic need. (The factors leading to the improvement of economic conditions also increased the need for other services, such as day care of children of working mothers and services to travelers.) However, there was no diminution of need for other services, and the decreases in the volume of such services represent a decrease in ability of agencies to meet the need. The withdrawal of medical, nursing, and other technical personnel for service in the armed forces resulted in a shortage of such personnel to serve the civilian population. In the face of the needs of the armed services, of national war-service programs, and of private industry, it was difficult for health and welfare agencies to retain adequate professional, clerical, and maintenance staffs. Child-welfare agencies found it almost impossible to find enough foster-family homes, because of heavy migration to war-production centers, housing shortages, and the employment in industry of potential foster mothers. These wartime pressures presented communities with the necessity for careful planning of their health and welfare programs which will need to continue when the Nation returns to a peacetime economy.

CHILD WELFARE

The changes from 1942 in the volume of protective and foster care of children, of day-care services, and of maternity-home care represent, for the most part, a continuation of the changes noted for the period 1940–42. For all the areas combined there was a decrease between 1942 and 1943 in protective and foster care and in maternity-home care and a marked increase in day-care services. These three types of service do not encompass the total program of services to children in the urban areas participating in the social-statistics project. Other services directly affecting the health and welfare of children, such as aid to dependent children and child-guidance services, are classified in other fields. In addition, other services provided for children in the reporting areas, such as special types of care for physically and mentally handicapped children, are not represented in the statistics reported to the Children's Bureau.

Protective and foster care

During 1943 the average number of children receiving protective and foster care on the last day of the month in the 33 areas reporting this type of service was 78,598 (table 2). Of this number 36 percent were served in their own or in relatives' homes, 36 percent in foster-family homes, and 28 percent in institutions.

TABLE 2.—*Child welfare: Average number of children receiving selected types of service at end of month, 1943, and percent change from 1942, by agency auspices; 43 urban areas*

Type of service	Children receiving service, 1943				Percent change from 1942		
	Total	Percent	Under public auspices	Under private auspices	Total	Public	Private
Protective and foster care, total	78,598	100	25,404	53,194	−6	−4	−8
In parents' homes	24,228	31	5,701	18,527	−10	−4	−12
In relatives' homes	4,278	5	1,950	2,328	−7	(1)	−12
In foster-family homes	28,019	36	15,171	12,848	−5	−3	−7
In institutions	22,073	28	2,582	19,491	−4	−6	−4
Day care	14,464	100	5,144	9,320	(2)	(2)	(2)
Maternity-home care [3]	1,779	100	5	1,774	−7	(4)	−7

[1] Increase less than 0.5 percent.
[2] Change not computed, figures for the 2 years not comparable.
[3] Excludes infants.
[4] Change not computed, 1942 figure less than 50.

Approximately one of every three children receiving protective and foster care was served by a public agency. As has been indicated in previous Children's Bureau publications,[6] however, this ratio does not represent the full contribution of public funds used for this type of service, inasmuch as significant amounts of public moneys are expended by agencies providing this service under private auspices. Three-fifths of all the children receiving protective and foster care from public agencies were in foster-family homes.

More than half (54 percent) of all the children in foster-family homes were served under public auspices. However, 88 percent of the children in institutions and 73 percent of the children served in their own or relatives' homes were under the supervision of private agencies.

The average number of children

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[6] "Community Health and Welfare Expenditures in Wartime," by Edward E. Schwartz and Eloise R. Sherman (Bureau Pub. No. 302. Washington, 1944); and "Changes in Volume of Health and Welfare Services, 1940–42." (See footnote 2.)

receiving protective and foster care was 6 percent lower in 1943 than in 1942, the net effect of decreases of 4 to 10 percent in the types of care included under this heading. The number served by public and by private agencies decreased 4 and 8 percent respectively. Both public and private agencies reported a decrease in each type of care except care in relatives' homes, for which the number of children served by public agencies increased slightly. The greatest over-all decrease from 1942 to 1943 occurred in the number of children served in their own homes; the greatest decrease for private agencies was in the number of children served in their own homes and in homes of relatives, and for public agencies in the number of children receiving institutional care.

The different rates of decrease reported for public and private agencies indicate the growing relative importance of public agencies in the provision of protective and foster care of children. Significantly, institutional care was the only type of care for which public agencies reported a greater decrease than private agencies. The changing role of public and private agencies in the provision of foster-family and institutional care is shown in a recent Children's Bureau study, which found that in 27 States and the District of Columbia such care under public auspices increased 36 percent between 1933 and 1943 and under private auspices decreased 19 percent. This change in the 10-year period was even more marked for foster-family care alone. The volume of such care under public auspices increased 70 percent, and the volume under private auspices decreased 13 percent.[7]

The changes from 1942 to 1943 in individual areas show some variation (though not as great as in previous years) from the changes noted for all areas combined. Nine areas reported increases from 1942 in the number of children receiving such service in their own homes; 10, increases in the number of those receiving such service in relatives' homes; 12, increases in foster-family care; and 9, increases in institutional care (table 3).

TABLE 3.—*Child welfare: Variations in percent change from 1942 to 1943 in average number of children receiving selected types of service at end of month; 43 urban areas*

Type of service	Percent change			Number of areas					
	Total	Range		Showing—			For which change not computed [2]	Reporting no organized service	Not reporting
		From—	To—	Increase [1]	Decrease [1]	No change			
Protective and foster care, total.	−6	+16 (Wichita)	−26 (Cincinnati)	7	26	----------	----------	----------	10
In parents' homes	−10	+35 (New Haven)	−43 (Denver)	9	21	1	1	1	10
In relatives' homes	−7	+38 (Syracuse)	−46 (Cincinnati)	10	15	1	6	1	10
In foster-family homes	−5	+19 (Sioux City)	−16 (Cleveland)	12	20	----------	1	----------	10
In institutions	−4	+12 (Minneapolis)	−18 (Richmond)	9	24	----------	----------	----------	10
Maternity-home care	−7	+53 (Minneapolis)	−18 (St. Louis)	4	11	----------	22	3	3

[1] Exclusive of areas for which 1942 figure is less than 50.
[2] Figures for 1942 less than 50.

In table 4 are presented the 1943 data showing for each of the 33 areas the average number of children receiving service in foster-family homes at the end of the month. Although there was an over-all decrease of 3 percent from 1942 in the volume of foster-family care provided by public agencies, 9 areas reported increases in the volume of such care, the highest increase (27 percent) being reported by Richmond. Similarly, although private-agency foster-family care in the 33 areas combined decreased 7 percent from 1942, 8 areas reported increases in the volume of such care, the highest increase (24 percent) being reported by Akron. In only 4 areas—Cincinnati, New Orleans, Birmingham, and Richmond—did both public and private agencies report increases in foster-family care. The decreases in foster-family care do not in all instances represent a decreased need for such care; reports from several areas indicate that individual agencies have experienced a constant demand for more foster-family homes than are available to them.

The 4-percent decrease in institutional care of dependent and neglected children in the 33 areas combined was the result of decreases in 24 areas, ranging from less than 1 percent in Cleveland to 18 percent in Richmond, and increases in 9 areas, ranging from 1 percent in Pittsburgh, Akron, and Denver to 12 percent in Minneapolis.

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[7] "Changes in Volume of Foster Care, 1933–43," by J. S. Fuerst. Social Statistics, Supplement to *The Child*, June 1945.

TABLE 4.—*Child welfare: Average number of children receiving foster-family care at end of month, 1943, and percent change from 1942, by agency auspices; 33 urban areas*

Area	Children receiving foster-family care, 1943			Percent change from 1942		
	Total	Under public auspices	Under private auspices	Total	Public	Private
Total, 33 areas	28,019	15,171	12,848	−5	−3	−7
Chicago	4,779	1,516	3,263	−6	−3	−8
Los Angeles	2,127	1,289	838	−3	−2	−4
Pittsburgh	1,780	1,400	380	−6	−6	−9
Cleveland	2,236	1,640	596	−16	−18	−11
St. Louis	1,750	1,238	512	−6	−5	−7
Baltimore	1,009	488	521	−8	−1	−13
Buffalo	1,543	1,229	314	−9	−9	−8
Milwaukee	769	230	539	−3	+3	−5
San Francisco	1,127	----------	1,127	−14	----------	−14
Cincinnati	965	374	591	+7	+13	+4
Houston	432	59	373	−6	(1)	−7
Minneapolis	950	526	424	(2)	+18	−17
New Orleans	266	164	102	+14	+13	+15
Atlanta	446	266	180	−7	−8	−5
Kansas City, Mo.	605	273	332	+8	+26	−4
Birmingham	431	294	137	+14	+17	+7
Dallas	170	102	68	+6	−10	(3)
Columbus	513	311	202	+4	(2)	+12
Louisville	651	474	177	+1	−4	+18
Akron	360	156	204	+10	−3	+24
Denver	510	293	217	+2	+3	(2)
St. Paul	1,089	685	404	−7	−4	−11
Dayton	395	147	248	+1	−9	+8
Syracuse	557	432	125	−9	−10	−7
Richmond	437	250	187	+15	+27	+2
Providence	543	418	125	−7	−3	−17
Oklahoma City	78	----------	78	−13	----------	−13
Canton	540	320	220	−1	+6	−10
Fort Worth	17	----------	17	(3)	----------	(3)
New Haven	565	482	83	−4	−3	−13
Des Moines	189	57	132	−11	−8	−12
Wichita	122	19	103	−10	(3)	−19
Sioux City	68	39	29	+19	(3)	(3)

[1] No change.
[2] Decrease less than 0.5 percent.
[3] Change not computed, 1942 figure less than 50.

Day-care services

The marked increase in the employment of women during the war period has pointed up the need for providing adequate day care for children of working mothers. Prior to the war-stimulated employment of large numbers of women with children, organized day-care services on a nonprofit basis were provided for the most part by the traditional day nursery. Expansion of nursery-school programs, especially under the WPA, in many instances provided additional facilities for the day care of children, although the primary emphasis of these programs was educational. The cessation of the WPA nursery-school program (coincident with the liquidation of WPA) left many communities without any resources for meeting the need for day care of children of working mothers. Beginning in the early part of 1943, however, Lanham Act funds were made available to local communities for the provision of day-care services; as a result an unprecedented volume of such services was provided under public auspices.

The availability of funds, however, was only one facet of the problem of providing adequate day care of children. Well-trained and experienced personnel often were not immediately available, and necessary equipment could not always be obtained. Enrollment in day-care centers in some communities was slow in picking up, and attendance was spotty. It soon became evident that the provision of facilities for group care of children was not the sole solution to the problem. Arrangements had to be made for the care of sick children of employed mothers and of infants and other children needing more individual attention than could be provided under group arrangements. Intensive community education with regard to day-care services had to be undertaken. Counseling services had to be set up for employed women and those contemplating employment, in order to provide them an opportunity to discuss the problems attendant upon their employment in relation to their needs and those of their children.

Communities met these problems in various ways, establishing specific services to meet the specific needs as their resources would allow. The hours of operation of day-care centers were extended to conform more nearly to the needs of employed women. Some communities developed counseling services and programs of day care in foster-family homes. Inasmuch as Lanham Act funds were available only for group care of children, however, counseling and foster-family day-care services, when established, were supported by State and local public and private funds.

Although it is known that the volume of day-care services increased between 1942 and 1943, it is not possible to measure the increase on the basis of the reports obtained in the social-statistics project because the reporting procedures were revised for this type of service in 1943 in order to reflect more accurately the establishment of new services. In 1943 the average number of children in 32 areas receiving day-care services on the last day of the month was 14,464 (table 2). More than one-third of these children (5,144) were served under public auspices. An average of only 389 children were receiving day care in foster-family homes. Three areas—Canton, Grand Rapids, and Wilkes-Barre—reported that they had no organized day-care service.

Maternity-home care

In 1943 the average number of women receiving care in maternity homes at the end of the month (1,779) was 7 percent lower than in 1942 in the 37 areas for which data are available (table 2). As in previous years more than 99 percent of the maternity-home care in these areas was provided under private auspices. This decrease in the volume of maternity-home care can probably be explained by a combination of factors, such as the increased mobility and improved economic condition of the population during the war period, which made it easier for unmarried mothers to leave their home communities or to remain in their home communities without this specialized care, and the staff shortages experienced by most institutional programs which made it more difficult to provide service.

Twenty-two areas reported a monthly average in 1943 of less than 50 women under care. Of the 15 areas reporting more than 50 cases per month, 4 reported increases, ranging from 2 percent in Milwaukee to 53 percent in Minneapolis, and 11 reported decreases, ranging from 4 percent in Columbus to 18 percent in St. Louis (table 3).

FAMILY WELFARE AND RELIEF

The volume of service declined between 1942 and 1943 in all the nine types of service classified under the heading, "Family welfare and relief," except in such service by private agencies.[8] The greatest decrease—almost half—was reported for public general relief, which also had declined markedly from 1940 to 1942. Substantial declines also were reported in shelter care and in aid to dependent children.

Family welfare and relief, private agencies

The average monthly number of cases served by private family-service agencies in 37 areas in 1943 (144,582) was 58 percent higher than in the previous year. This increase, however, was the result solely of the expanded activities of the home-service departments of the American Red Cross chapters in the reporting areas, which in 1943 accounted for 72 percent of all service reported in this field, compared with 40 percent in 1942. The effect of the change in the volume of service provided by the American Red Cross chapters on the change in the total volume of service provided by private family agencies is clearly evident from the following data on average monthly case loads:

	1942	*1943*	*Percent change, 1942–43*
All private family-welfare agencies (37 areas)	91,480	144,582	+58
American Red Cross	36,967	103,562	+180
Other private family-welfare agencies	54,513	41,020	−25

A marked change also is evident in the types of cases reported by private family agencies. The number of cases receiving financial assistance decreased 4 percent from 1942 to 1943, the net effect of an increase of 132 percent in the number of cases given assistance by home-service departments of American Red Cross chapters and a decrease of 28 percent in the number of cases receiving financial assistance from other private family-welfare agencies. The proportion of all cases that received assistance decreased from 25 percent in 1942 to 15 percent in 1943. However, the average monthly payment per case increased from $20.76 in 1942 to $25 in 1943 because assistance budgets were adjusted to changes in the cost of living and because such payments were less frequently used to supplement public-assistance grants. Coincident with the decline in the provision of assistance by these agencies has been the addition of new services. In many areas the staff of private agencies conducted investigations for selective-service boards on agency time and on their own time. The family agency in Syracuse inagurated a new child-counseling service. The family agency in Dallas broadened its program to include service to travelers and transients.

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[8] Although it is known that service to travelers and transients increased greatly because of the wartime mobility of the civilian population and of the armed forces, the extent of this increase cannot be measured from the social-statistics project reports on this service because of a change in reporting procedures, effective in 1943.

Public general relief

The average monthly number of cases receiving general relief from public agencies in 42 areas dropped 47 percent—from 185,118 in 1942 to 98,754 in 1943. Inasmuch as general-relief expenditures decreased only 40 percent during the same period, the average monthly payment per case increased from $26.78 in 1942 to $30.30 in 1943. In view of the fact that the general-relief case load each year since 1940 has included a larger proportion of single-person cases,[9] this increase in the average monthly payment per case represents a still greater increase in the average monthly payment per person. The higher average monthly payments indicate an increase in budgetary allowances directed toward more nearly adequate assistance grants to meet a greater proportion of the recipients' need, to offset increases in the cost of living, and to meet the budgetary deficiencies resulting from discontinuance of the food-stamp plan and of the direct distribution of surplus commodities.

Every area reported a decrease in the average monthly number of cases receiving public general relief, ranging from 12 percent in Birmingham to 62 percent in Milwaukee (table 5). Fifteen areas reported decreases of 50 percent or more, and only 3 areas—Birmingham, New Orleans, and Richmond—reported decreases of less than 25 percent. The small decrease in Birmingham is in part related to the increased availability of funds for assistance at the beginning of Alabama's new fiscal year, October 1943. Generally the number of cases receiving public general relief and the expenditures for such relief do not indicate completely the need for assistance inasmuch as both are affected by such factors as the availability of funds for assistance and the policies of administrative agencies concerning eligibility for assistance.

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[9] Federal Security Agency, Social Security Board: *Social Security Yearbook, 1943*, p. 49. Washington.

TABLE 5.—*Family welfare and relief: Variations in percent change from 1942 to 1943 in average monthly figures for selected types of service; 43 urban areas*

Type of service	Percent change			Number of areas					
	Total	Range		Showing—			For which change not computed[2]	Reporting no organized service	Not reporting
		From—	To—	Increase[1]	Decrease[1]	No change			
Family welfare and relief, private agencies.	+58	+146 (Atlanta)	−56 (Minneapolis)	35	2	----	----	----	6
Public general relief	−48	−12 (Birmingham)	−62 (Milwaukee)	----	42	----	----	----	1
Special types of public assistance:									
Aid to dependent children.	−22	+27 (Hartford)	−54 (Fort Worth)	7	36	----	----	----	----
Old-age assistance	−3	+18 (New Orleans)	−13 (Baltimore)	8	34	----	----	----	1
Aid to the blind	−3	+35 (Houston)	−22 (New Haven)	12	25	2	2	----	2
Shelter care (lodgings)	−31	+4 (Baltimore)	−99 (Des Moines)	1	30	----	----	4	8
Institutions for aged, etc.	−5	+9 (Dallas)	−56 (Akron)	5	20	----	----	1	17
Legal aid	−18	+35 (San Francisco)	−61 (Kansas City, Mo.)	4	18	1	4	9	7

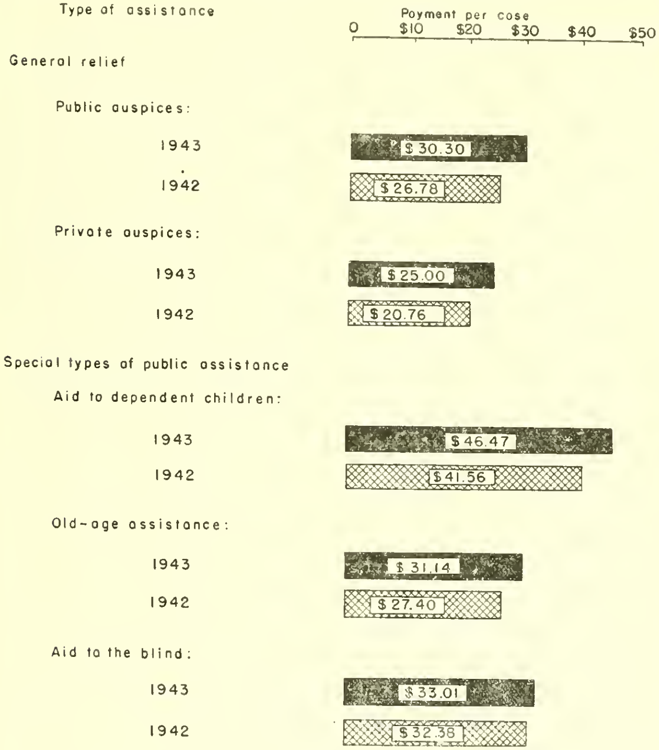
[1] Exclusive of areas for which 1942 figure is less than 50.
[2] Figure for 1942 less than 50.

Special types of public assistance

Comparable reports for 1942 and 1943 are available on aid to dependent children for 43 areas, on old-age assistance for 42 areas, and on aid to the blind for 41 areas. The combined reports of the areas show decreases in the average monthly number of cases receiving such assistance, as follows: Aid to dependent children, 22 percent; old-age assistance, 3 percent; and aid to the blind, 3 percent. These reports also showed the following increases in the average monthly payment per case for each type of assistance: $0.63 for aid to the blind, $3.74 for old-age assistance, and $4.91 for aid to dependent children (fig. 2).

The average monthly number of cases receiving aid to dependent children increased in 7 areas and decreased in 36 areas; 3 areas reported decreases of 50 percent or more. The greatest increases were reported by Hartford (27 percent) and New Haven (15 percent) and seem to represent the continued expansion of the Federal-State program of aid to dependent children initiated in Connecticut in December 1941.

FIGURE 2.—*Average monthly payment per case, 1942 and 1943, by type of assistance; 43 urban areas*



The changes in individual areas in the average monthly number of cases receiving old-age assistance ranged from an increase of 18 percent in New Orleans to a decrease of 13 percent in Baltimore; and in the number of cases receiving aid to the blind, from an increase of 35 percent in Houston to a decrease of 22 percent in New Haven. Eight areas reported increases in the number of cases receiving old-age assistance, and 12 in the number receiving aid to the blind; 34 areas reported decreases in the number receiving old-age assistance, and 25 in the number receiving aid to the blind. In large measure the increases reflect the liberalization of eligibility requirements in individual programs of assistance or the continued expansion of recently initiated programs.

The special types of public assistance were less affected by the heightened wartime industrial activities than were the general-relief programs, although the sizable decrease in aid to dependent children indicates that this program was more responsive to economic changes than were the other two special-assistance programs. All assistance programs were affected to some extent by the growth of the armed forces during 1943 and the consequent increase in allowances and allotments from relatives under the Servicemen's Dependents Allowance Act. Although increased employment opportunities and greater contributions from relatives resulted in some decreases in old-age assistance and aid to the blind, the most marked effect of these factors is noted in the program of aid to dependent children. The unprecedented recruitment of women for employment regardless of previous work experience or family responsibilities, the large-scale employment of adolescents who left school for full-time jobs, and the after-school employment of school-age children in many instances increased family incomes, resulting in the discontinuance of assistance.

Other services

Shelter care [10] on a temporary basis for needy homeless and transients, the need for which is obviously affected by economic conditions, continued to decline. The average monthly number of lodgings provided in 31 areas dropped 31 percent—from 259,964 in 1942 to 179,062 in 1943; the average monthly number of meals provided dropped 40 percent—from 628,148 in 1942 to 376,577 in 1943. In 1943 seven-eighths of the shelter care in the reporting areas was provided by private agencies. The decreases between 1942 and 1943 in the volume of service was much greater for public agencies (lodgings, 62 percent, and meals, 65 percent) than for private agencies (lodgings, 22 percent, and meals, 29 percent.)

The average monthly number of days' care provided in institutions for aged, chronically ill, and dependent adults decreased 5 percent—from 864,885 in 1942 to 822,069 in 1943—in the 25 areas for which comparable data are available. Public agencies reported a decrease of 9 percent, and private agencies an increase of less than 1 percent. Decreases were reported by 20 areas, ranging from 1 percent in Baltimore to 56 percent in Akron; increases were reported by 5 areas, ranging from less than 1 percent in Cincinnati to 9 percent in Dallas (table 5).

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[10] Meals and lodgings provided by self-supporting agencies and commercial lodginghouses operated for persons of low income are not included in these data.

The average monthly number of legal-aid cases opened decreased 18 percent—from 8,784 in 1942 to 7,174 in 1943—in the 27 areas for which comparable data are available. This service was provided under public auspices in six areas—Columbus, Des Moines, Hartford, Kansas City, Mo., New Haven, and St. Louis. The average number of cases opened by public agencies decreased 51 percent compared with a decrease of 13 percent in the number opened by private agencies.

HEALTH

The general picture of changes in health programs between 1942 and 1943 is that of decreases of varying degree in the volume of all types of service for which reports are obtained in the social-statistics project. All the types of service included in this field were provided under both public and private auspices.

Hospital in-patient service [11]

Hospital in-patient service, for the purpose of this report, is classified according to the type of hospital in which it is provided: (1) General and special and (2) tuberculosis and chronic illness. In 1943 almost seven-eighths of all in-patient service was provided in general and special hospitals. Public hospitals provided 28 percent of the total patient-days in general and special hospitals, and 82 percent of the total in hospitals for tuberculosis and for chronic illness.

In 1943, for the first time since the beginning of the war, the volume of in-patient service in general and special hospitals decreased from the preceding year. In the 31 areas for which data are available for both years the average monthly number of patient-days' care provided in these hospitals declined less than 1 percent—from 2,312,221 in 1942 to 2,310,645 in 1943 (table 6). This slight decrease is the net effect of a 3-percent decline in service provided by public hospitals and a 1-percent increase in that provided by private hospitals. However, inasmuch as total admissions to general and special hospitals increased somewhat between the 2 years, it is evident that the decrease in patient-days represents a slight decline in the average length of stay in these hospitals rather than in the number of patients served. Total admissions—to public and private hospitals combined—increased less than 1 percent; admissions to public hospitals decreased 7 percent; and admissions to private hospitals increased 2 percent. Variations among the reporting areas in changes in the volume of service are indicated in table 7 and table 11.

The general improvement in economic conditions, the increased coverage under insurance plans providing for prepayment of hospital costs, and the purchase of

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[11] Services provided by hospitals conducted for profit; industrial hospitals; hospitals caring for the mentally ill, epileptic, feeble-minded, blind, or deaf; and veterans' hospitals are excluded from these data.

TABLE 6.—*Health: Average monthly figures for selected types of service, 1943, and percent change from 1942, by agency auspices; 43 urban areas*

Type of service	Volume of service, 1943			Percent change from 1942		
	Total	Under public auspices	Under private auspices	Total	Public	Private
Hospital in-patient service (patient-days):						
General and special	2, 310, 645	650, 642	1, 660, 003	(1)	−3	+1
Tuberculosis and chronic	362, 161	298, 591	63, 570	−6	−7	−1
Medical service:						
Clinic, other than mental hygiene (visits)[2]	857, 568	516, 046	341, 522	−17	−16	−19
Mental-hygiene clinic (cases)	3, 858	866	2, 992	−9	−13	−8
In patient's home or doctor's office (visits)	34, 210	30, 130	4, 080	−32	−33	−27
School health programs (examinations)[3]	72, 398	71, 566	832	−1	−1	+29
Public-health nursing (visits)[4]	384, 955	233, 315	151, 640	−6	−5	−8
Maternity service (visits)	48, 958	16, 669	32, 289	−14	−15	−13
Medical-social service (patients)	34, 603	12, 026	22, 577	−14	−10	−16

[1] Decrease less than 0.5 percent.
[2] Does not include visits to separately organized mental-hygiene clinics.
[3] Limited to separately organized school health programs.
[4] Includes both field and office visits, except office visits provided in separately organized school health programs.

TABLE 7.—*Health: Variations in percent change from 1942 to 1943 in average monthly figures for selected types of service; 43 urban areas*

Type of service	Percent change			Number of areas					
	Total	Range		Showing—			For which change not computed [2]	Reporting no organized service	Not reporting
		From—	To—	Increase [1]	Decrease [1]	No change			
Hospital in-patient service (patient-days):									
General and special	(3)	+11 (Des Moines)	−26 (Birmingham)	20	11				12
Tuberculosis and chronic	−6	+15 (Columbus)	−33 (New Orleans)	5	25			1	12
Medical service:									
Clinic, other than mental hygiene (visits) [4].	−17	+7 (Birmingham)	−57 (Wichita)	3	34				6
Mental-hygiene clinic (cases)	−9	+61 (Los Angeles)	−75 (Hartford)	11	13		1	8	10
In patient's home or doctor's office (visits).	−32	+66 (Syracuse)	−75 (Oklahoma City)	1	28			1	13
School health programs (examinations) [5]	−1	+316 (Birmingham)	−78 (Canton)	10	21		2	3	7
Public-health nursing (visits)[6]	−6	+8 (Atlanta)	−33 (Wichita)	7	29				7
Maternity service (visits)	−14	+24 (Akron)	−49 (Wichita)	2	34				7
Medical-social service (patients)	−14	+286 (Milwaukee)	−79 (Baltimore)	5	18			11	9

[1] Exclusive of areas for which 1942 figure is less than 50.
[2] Figure for 1942 less than 50.
[3] Decrease less than 0.5 percent.
[4] Does not include visits to separately organized mental-hygiene clinics.
[5] Limited to separately organized school health programs.
[6] Includes both field and office visits, except office visits provided in separately organized school health programs.

TABLE 8.—*Health: Average monthly figures for in-patient service provided by hospitals of specified types, by auspices, 1943; 31 urban areas*

Type of hospital and auspices	Number of hospitals	Admissions [1]	Patient-days		
			Total	Free to patient	
				Number	Percent of total
General and special	404	171,773	2,310,645	761,604	33
Public	62	32,427	650,642	556,937	86
Private	342	139,346	1,660,003	204,667	12
Tuberculosis and chronic	61	1,222	362,161	303,674	84
Public	38	930	298,591	273,076	91
Private	23	292	63,570	30,598	48

[1] Exclusive of births.

hospital care under the EMIC program are reflected in the 10-percent decrease between 1942 and 1943 in free patient-days. In 1943, 33 percent of all patient-days in general and special hospitals—public and private—were free. In public hospitals 86 percent of all patient-days were free and in private hospitals 12 percent (table 8).

Almost one-fifth of total admissions (exclusive of births) to general and special hospitals in 1943 were accounted for by maternity cases, and approximately one-sixth by children under 14 years of age. Admissions of maternity cases increased 2 percent between 1942 and 1943, and of children under 14 years of age less than 1 percent. Decreases in admissions to public hospitals were offset by increases in admissions to private hospitals. The experience of the individual areas is indicated in table 9, which shows the number of maternity cases and of children under 14 years of age admitted and the number of live births reported by general and special hospitals in each area in 1943.

The average monthly number of patient-days provided in hospitals for tuberculosis and chronic illness decreased 6 percent—from 386,248 in 1942 to 362,161 in 1943—the cumulative effect of a 7-percent decline in public-hospital service and a 1-percent decline in private-hospital service. Only 5 areas—Cincinnati, Columbus, Des Moines, Oklahoma City, and Richmond—reported increases between the 2 years in the volume of service provided in hospitals for tuberculosis and chronic illness; 25 areas reported decreases in this service. The average monthly number of admissions to these hospitals decreased 11 percent—from 1,366 in 1942 to 1,222 in 1943. Admissions to public hospitals decreased 13 percent, but admissions to private hospitals increased slightly.

TABLE 9.—*Health: Average monthly number of maternity cases and children under 14 years of age admitted and of live births reported, general and special hospitals, 1943, and percent change from 1942; 31 urban areas*

Area	Admissions		Live births	Percent change from 1942		
				Admissions		Live births
	Maternity cases	Children under 14 years of age		Maternity cases	Children under 14 years of age	
Total, 31 areas	32, 867	27, 076	30, 095	+2	(1)	+3
Public auspices	4, 428	5, 375	3, 667	−10	−7	−9
Private auspices	28, 439	21, 701	26, 428	+5	+2	+4
Chicago	5, 035	4, 071	4, 531	−2	−4	−1
Detroit	3, 211	2, 247	3, 029	(1)	−9	+1
Pittsburgh	2, 216	2, 094	2, 051	−2	+11	−1
Cleveland	1, 955	1, 394	1, 770	−2	+4	−3
St. Louis	1, 766	1, 375	1, 606	+3	+3	+5
Baltimore	1, 831	1, 412	1, 652	+7	+4	+7
Buffalo	1, 339	1, 047	1, 249	+5	+7	+5
Milwaukee	1, 239	1, 338	1, 178	+2	+6	+1
Washington, D. C	1, 455	1, 090	1, 318	+7	−6	+7
San Francisco	1, 151	967	1, 058	+17	−5	+18
Cincinnati	1, 110	1, 220	1, 025	(1)	+6	(2)
New Orleans	1, 225	1, 632	1, 149	+4	−5	+9
Atlanta	794	463	725	−4	+7	−2
Kansas City, Mo	770	595	697	+6	−5	+7
Birmingham	326	332	290	−28	−38	−27
Dallas	707	474	631	+13	−7	+12
Columbus	642	465	604	+9	+17	+8
Akron	615	518	571	+6	+19	+6
St. Paul	635	660	567	+9	−3	+5
Dayton	637	402	595	+8	+26	+7
Syracuse	536	410	466	+4	+11	+2
Richmond	360	363	251	+14	+13	+12
Providence	748	4/2	685	+2	+3	+3
Grand Rapids	379	281	345	+1	+1	(2)
Oklahoma City	235	278	225	+7	−17	+7
Canton	463	256	443	+2	+31	+5
Fort Worth	403	226	370	−1	−11	(3)
New Haven	438	247	423	+7	+2	+7
Wilkes-Barre	209	215	180	+3	−8	+2
Des Moines	260	296	248	(3)	+1	+4
Sioux City	177	236	163	+5	+11	+6

[1] Increase less than 0.5 percent.
[2] Decrease less than 0.5 percent.
[3] No change.

Clinic service (other than mental hygiene)

In 1943 the average monthly number of visits to clinics (other than separately organized mental-hygiene clinics) and to health conferences was 857,568 in the 37 areas for which data are available, a decrease of 17 percent from the preceding year and a continuation of the decline noted since 1939 in these visits. Thirty-four areas reported decreases from 1942 in the number of visits, and only 3 areas—Atlanta, Birmingham, and Canton—reported increases. The greatest decrease was reported by Wichita (57 percent), 8 other areas reporting decreases of 30 percent or more. In the 37 areas combined, visits to clinics and health conferences held under public auspices decreased 16 percent and visits to those held under private auspices decreased 19 percent.

Public-health-nursing service

The decline in public-health-nursing service, as measured by the number of field and office visits, which was noted in previous years,[12] continued through 1943. The average monthly number of visits in that year (384,955) was 6 percent lower than in 1942 in the 36 areas reporting for both years. This decrease was the cumulative effect of decreases of 5 and 8 percent, respectively, in public and in private service. Slightly more than three-fifths of the nursing visits in 1943 were made under public auspices. However, private agencies reported almost twice as many visits to maternity cases (32,289) as did public agencies (16,669). Twenty-one percent of all private-agency visits were maternity-case visits, compared with 7 percent of public-agency visits. Of the 36 areas reporting public-health-nursing service, 29 reported decreases in total service in 1943 as compared with 1942, and 7 reported increases.

Other health services

Significant changes also were reported between 1942 and 1943 in the other four types of service included in the health field. The sharpest decrease in health service (32 percent) was reported for medical care provided by health and welfare agencies in the patient's home or the doctor's office. This decrease reflects not only a probable decline in the need for such service but also an inability to provide it—the most expensive type of health service in terms of utilization of professional time—in view of the wartime shortages of medical personnel. The average monthly number of patients receiving medical-social service decreased 14 percent, the cumulative effect of decreases of 10 and 16 percent in the service provided by public and by private agencies, respectively (table 6). In 1943 slightly less than two-thirds of the medical-social service was provided by private agencies. Service of mental-hygiene clinics declined 9 percent, the combined effect of a 13-percent decrease in the average monthly number of cases served under public auspices and an 8-percent decrease in the number served under private auspices. The average monthly number of medical examinations under school health programs decreased 1 percent—from 73,120 in 1942 to 72,398 in 1943. Almost all such examinations were provided under public auspices in 1943, and these decreased 1 percent; examinations under private auspices increased 29 percent.

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[12] Social Statistics, Supplements to *The Child*, November 1942, pp. 12–16; and October 1944, p. 14.

GROUP WORK

During 1943 the monthly attendance at organized group activities of private leisure-time agencies averaged 2,161,364 in the 32 areas for which data are available for both years, a decrease of 6 percent from 1942. This was the net effect of increases in 6 areas, ranging from 3 percent in Milwaukee to 32 percent in Omaha, and of decreases in 26 areas, ranging from less than 1 percent in Dallas and Denver to 24 percent in Akron.

In contrast to this decrease in attendance at group activities, the average end-of-the-month membership in the national-program groups (Boy Scouts, Girl Scouts, and Camp Fire Girls) in the 35 reporting areas increased 10 percent in 1943 over 1942. Only 3 of these areas—Columbus, Newark, and New Haven—reported decreases in the average end-of-the-month membership.

SOCIAL-SERVICE EXCHANGE

The average monthly number of clearings by social-service exchanges in the 40 areas reporting comparable data for both years decreased 10 percent—from 206,847 in 1942 to 186,387 in 1943. Ten areas reported increases in the number of clearings, ranging from less than 1 percent in Grand Rapids to 56 percent in New Haven; 30 areas reported decreases, ranging from 1 percent in Des Moines to 44 percent in Wilkes-Barre. All the exchanges for which data are included operated under private auspices except the one in St. Paul, which reported a 32-percent increase in the number of clearings.

At various times, the volume of social-service exchange clearings has been used as an indicator of the extent of demands for service from community health and welfare agencies. Inasmuch as the use of the social-service exchange has become widespread in recent years, extending to situations not involving service to individuals (for example, clearings for selective-service boards), and in view of variations in clearing policies, the number of clearings has become a less sensitive indicator of the need for health and welfare services in individual communities. However, when considered together with the reports of the operating agencies, the 10-percent decrease in clearings between 1942 and 1943 indicates a decrease in the intake activities of health and welfare agencies.

TABLE 10.—*Average monthly figures for selected types of health and welfare service as reported by each of 43 urban areas, 1943*

Area [1]	Child welfare							Family welfare and relief									
	Children under protective and foster care					Day-care services (children served)	Women under care in maternity homes	Private agencies (cases)	Cases receiving public assistance				Service and relief to transients and travelers (cases)	Institutional care			Legal aid (cases opened)
	Total	In parents' homes	In relatives' homes	In foster-family homes	In institutions				Public general relief	Special types of assistance				Shelter		Days' care to aged, etc.	
										Aid to dependent children	Old-age assistance	Aid to the blind		Meals	Lodgings		
All areas reporting, total	78,598	24,228	4,278	28,019	22,073	14,464	1,779	144,582	98,754	57,273	383,709	14,627	10,255	376,577	179,062	822,069	7,174
Public auspices	25,404	5,701	1,950	15,171	2,582	5,144	5	144,582	98,754	57,273	383,709	14,627	148	66,647	22,151	439,362	604
Private auspices	53,194	18,527	2,328	12,848	19,491	9,320	1,774	-----	-----	-----	-----	-----	10,107	309,930	156,911	382,707	6,570
Chicago	10,920	1,626	263	4,779	4,252	1,806	131	21,410	24,659	12,068	51,557	2,067	1,479	30,539	24,925	203,607	(2)
Los Angeles	5,552	1,688	162	2,127	1,575	(2)	93	18,517	5,248	2,613	66,242	3,126	914	41,006	11,189	(2)	(2)
Detroit	(2)	(2)	(2)	(2)	(2)	1,380	133	5,452	6,269	4,888	14,846	257	753	(2)	(2)	97,781	1,571
Pittsburgh	6,718	3,051	405	1,780	1,482	166	84	5,910	7,951	5,454	13,161	1,377	378	61,259	26,035	(2)	334
Cleveland	5,032	1,522	294	2,236	980	972	91	6,189	3,832	1,371	10,438	317	554	25,748	8,042	(2)	342
St. Louis	3,533	400	148	1,750	1,235	647	65	6,966	2,711	2,766	14,565	639	(2)	28,964	10,072	(2)	55
Baltimore	2,227	308	121	1,009	789	658	17	3,082	3,473	1,563	5,816	300	303	6,821	8,650	52,288	466
Buffalo	4,459	1,166	396	1,543	1,354	491	78	3,492	2,552	434	4,177	115	188	22,164	15,137	49,128	391
Boston	(2)	(2)	(2)	(2)	(2)	(2)	110	7,833	5,494	2,814	15,135	320	1,508	18,459	9,452	(2)	705
Milwaukee	2,242	268	133	769	1,072	80	62	5,536	2,398	1,078	8,602	351	219	13,190	9,041	45,898	210
Washington, D. C	(2)	(2)	(2)	(2)	(2)	(2)	(2)	3,396	965	802	3,129	274	(2)	(2)	(2)	(2)	209
San Francisco	2,977	836	107	1,127	907	848	87	7,373	1,614	384	11,112	471	279	1,125	1,074	71,533	342
Cincinnati	4,280	2,249	277	965	789	799	64	3,696	2,687	753	10,142	263	291	16,375	6,347	65,293	411
Houston	1,081	284	75	432	290	358	24	2,633	808	405	9,452	282	138	1,146	537	4,759	(3)
Minneapolis	3,456	2,113	231	950	162	189	130	2,717	1,903	855	11,603	210	(2)	(2)	(2)	21,514	103
New Orleans	1,793	755	154	266	618	(2)	34	2,841	1,150	3,471	6,248	385	243	3,961	2,770	30,169	71
Atlanta	861	91	47	446	277	790	22	3,449	1,140	743	7,416	286	422	1,238	330	11,667	234
Kansas City, Mo	2,172	938	81	605	548	619	34	3,249	1,189	738	10,151	379	489	35,195	10,245	28,303	295
Indianapolis	(2)	(2)	(2)	(2)	(2)	503	21	2,735	747	1,220	6,903	308	163	8,349	4,716	(2)	88
Birmingham	720	72	38	431	179	(2)	34	1,579	692	1,075	2,292	97	257	2,116	750	6,609	(3)
Newark	(2)	(2)	(2)	(2)	(2)	452	17	(2)	2,496	1,620	(2)	(2)	142	14,587	6,971	(2)	(2)
Dallas	713	154	6	170	383	213	16	2,226	537	693	11,462	336	(3)	1,793	533	1,551	(2)
Columbus	1,205	185	38	513	469	274	49	2,782	1,479	349	8,190	262	77	(2)	(2)	19,005	17
Louisville	2,052	558	158	651	685	223	21	2,633	916	390	3,052	99	225	3,937	5,496	(2)	440
Akron	1,082	436	99	360	187	116	17	(2)	829	215	3,782	78	(3)	7,869	3,702	7,528	(2)
Denver	2,083	708	83	510	782	296	55	(2)	2,077	1,185	11,520	166	124	(4)	(4)	(2)	207
St. Paul	2,609	1,177	206	1,089	137	267	63	3,024	1,425	380	4,689	131	106	(2)	(2)	27,152	33
Dayton	1,019	239	82	395	303	170	5	1,300	546	272	5,472	112	(3)	87	62	8,498	(2)
Syracuse	1,671	457	90	557	567	(2)	6	1,752	1,585	238	3,243	57	26	2,869	2,182	26,840	(2)
Richmond	880	170	68	437	205	(2)	33	1,227	831	463	1,370	101	241	2,943	1,158	19,387	12
Providence	2,673	1,660	216	543	254	399	11	2,221	1,224	527	3,069	42	159	10,782	3,807	(2)	65
Hartford	(2)	(2)	(2)	(2)	(2)	(2)	(2)	1,186	(2)	368	2,132	64	129	(4)	(4)	(2)	117
Omaha	(2)	(2)	(2)	(3)	(2)	71	30	(2)	506	760	3,854	103	55	622	234	(2)	(3)
Grand Rapids	(4)	(4)	(4)	(4)	(4)	(3)	26	1,191	800	664	6,053	97	(3)	(3)	(3)	(2)	97
Oklahoma City	447	85	28	78	256	396	32	1,255	556	829	5,811	144	29	1,255	720	3,374	(3)
Canton	1,076	289	66	540	181	(3)	(3)	(2)	412	186	3,919	78	35	(3)	(3)	7,906	(3)
Fort Worth	389	(3)	(3)	17	372	70	15	1,473	287	263	7,338	158	62	1,307	547	3,711	(3)
New Haven	1,160	302	17	565	276	393	(3)	1,154	568	315	2,400	46	41	5,403	1,838	(2)	101
Wilkes-Barre	(2)	(2)	(2)	(2)	(2)	(3)	(3)	(2)	1,138	1,106	2,325	379	82	5,462	2,498	(2)	(3)
Des Moines	809	300	106	189	214	151	24	931	703	112	4,091	190	16	6	2	5,088	19
Springfield, Mass	(2)	(2)	(2)	(2)	(2)	179	(3)	860	687	173	2,573	(2)	113	(2)	(2)	(2)	239
Wichita	389	95	37	122	135	283	19	936	978	567	2,186	97	(3)	(3)	(3)	(3)	(3)
Sioux City	318	46	46	68	158	205	26	376	692	103	2,191	63	15	(3)	(3)	3,480	(3)

See footnotes at end of table.

TABLE 10.—*Average monthly figures for selected types of health and welfare service as reported by each of 43 urban areas, 1943*—Continued

Area [1]	Health												Group work		Social-service exchange (clearings)
	Hospital in-patient service						Medical service in—				Public-health nursing (field and office visits)	Medical-social service (patients)	Attendance at group activities of local agencies	Members of local groups on national-program registers [6]	
	General and special			Tuberculosis and chronic			Clinic—other than mental hygiene (visits)	Mental-hygiene clinic (cases)	Patient's home and doctor's office (visits)	School health programs (examinations)					
	Admissions [5]	Patient-days		Admissions	Patient-days										
		Total	Free		Total	Free									
All areas reporting, total	171,773	2,310,645	761,604	1,222	362,161	303,674	857,568	3,858	34,210	72,398	384,955	34,603	2,161,364	373,479	186,387
Public auspices	32,427	650,642	556,937	930	298,591	273,076	516,046	866	30,130	71,566	233,315	12,026			15,258
Private auspices	139,346	1,660,003	204,667	292	63,570	30,598	341,522	2,992	4,080	832	151,640	22,577	2,161,364	373,479	171,129
Chicago	27,445	356,563	121,442	171	50,402	46,106	173,930	(2)	(2)	(2)	(2)	(2)	(2)	(2)	16,192
Los Angeles	(2)	(2)	(2)	(2)	(2)	(2)	91,842	314	(2)	663	23,018	6,911	(2)	38,819	6,237
Detroit	15,529	198,307	64,915	135	27,888	22,947	63,349	(2)	3,686	706	49,405	1,155	136,857	29,558	(2)
Pittsburgh	11,629	176,033	44,741	47	16,017	14,166	32,880	302	6,856	(2)	(2)	1,865	(2)	19,378	12,046
Cleveland	9,188	128,110	41,394	32	12,913	12,696	30,621	(2)	2,292	5,722	23,475	4,683	148,321	17,156	12,006
St. Louis	10,579	158,053	59,968	56	21,192	18,046	51,905	261	664	5,075	13,539	3,592	199,826	23,329	10,564
Baltimore	8,867	144,864	54,309	132	52,425	42,469	(2)	547	1,477	(2)	(2)	320	56,430	16,362	5,374
Buffalo	6,431	93,453	20,372	28	11,773	10,563	15,695	266	(4)	7,434	15,703	840	(2)	18,572	3,493
Boston	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	3,167	(2)	(2)	4,223	(2)	13,576	(2)
Milwaukee	7,170	80,281	19,950	51	19,206	14,464	18,484	162	625	5,980	35,086	552	38,776	12,015	7,260
Washington, D. C	6,497	94,830	51,104	53	18,728	15,327	(2)	163	472	4,011	15,070	3,808	107,666	12,076	8,676
San Francisco	7,284	106,507	33,924	26	10,910	6,848	39,022	(2)	1,575	2,781	10,933	1,528	104,900	8,950	4,663
Cincinnati	6,168	80,471	23,049	172	33,311	22,201	23,017	148	1,794	3,836	13,078	(2)	122,399	13,032	7,106
Houston	(2)	(2)	(2)	(2)	(2)	(2)	21,131	128	152	2,473	5,455	(3)	60,042	11,285	3,949
Minneapolis	(2)	(2)	(2)	(2)	(2)	(2)	9,265	(2)	183	1,334	9,147	(2)	87,213	11,710	9,367
New Orleans	8,031	88,715	50,645	48	7,155	7,155	43,088	96	63	(3)	7,484	908	38,265	(2)	2,878
Atlanta	4,331	44,411	16,687	13	6,429	6,429	39,715	(3)	2,039	3,056	9,256	345	(2)	7,412	4,194
Kansas City, Mo	4,434	60,355	21,067	19	5,484	5,370	11,042	75	782	1,259	8,549	(2)	60,629	(2)	5,007
Indianapolis	(2)	(2)	(2)	(2)	(2)	(2)	13,378	(2)	1,298	2,124	9,935	(3)	84,924	9,037	2,772
Birmingham	1,869	20,491	9,860	26	3,003	2,464	19,731	(3)	(3)	4,019	4,555	766	94,968	4,522	3,750
Newark	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	5,846	10,442	(2)	36,542	6,361	5,955
Dallas	4,087	41,924	15,777	18	2,970	2,970	22,463	100	470	909	10,751	(2)	71,220	8,465	2,510
Columbus	3,351	42,581	6,490	30	8,990	6,811	10,071	(2)	399	47	6,778	(2)	84,219	6,499	2,282
Louisville	(2)	(2)	(2)	(2)	(2)	(2)	25,659	165	397	(3)	11,655	228	37,900	6,099	5,212
Akron	2,521	25,832	1,412	15	3,991	3,161	6,967	71	167	998	12,871	(3)	45,973	(2)	1,171
Denver	(2)	(2)	(2)	(2)	(2)	(2)	8,776	120	1,449	1,340	6,562	525	81,886	8,225	3,279
St. Paul	3,741	53,409	19,447	2	2,374	2,034	7,568	138	656	281	6,611	(2)	32,892	8,805	15,258
Dayton	2,542	29,969	3,951	14	2,998	2,998	(2)	71	(2)	1,708	7,155	(3)	(2)	(2)	1,513
Syracuse	2,457	30,826	4,151	25	6,752	6,474	6,536	59	1,660	2,528	7,286	494	46,333	6,511	3,807
Richmond	1,575	27,651	17,761	18	6,267	5,798	11,349	232	(2)	1,052	7,274	384	68,094	4,585	3,525
Providence	2,832	67,054	25,787	37	15,566	11,662	9,771	52	(2)	1,557	10,413	(2)	58,616	3,701	(7)
Hartford	(2)	(2)	(2)	(2)	(2)	(2)	(2)	29	(3)	(2)	(2)	308	35,412	7,026	1,534
Omaha	(2)	(2)	(2)	(3)	(3)	(3)	8,314	(3)	(2)	(3)	3,871	(3)	52,113	6,742	2,471
Grand Rapids	1,712	21,933	4,326	12	3,302	3,187	2,817	(3)	(3)	(2)	(2)	252	(2)	5,508	1,011
Oklahoma City	1,371	21,694	9,467	5	1,647	1,647	3,115	51	364	743	1,776	(3)	23,054	9,437	634
Canton	1,812	18,503	1,199	14	3,329	2,642	1,125	(3)	(2)	213	3,802	(3)	(2)	(2)	677
Fort Worth	1,848	19,037	5,041	5	1,699	1,699	11,503	(3)	535	896	2,445	(3)	24,411	3,663	1,707
New Haven	2,263	31,857	3,976	(3)	(3)	(3)	8,476	119	261	679	11,125	337	36,426	3,888	2,704
Wilkes-Barre	1,095	13,852	6,033	6	1,741	1,741	4,344	(4)	(2)	(2)	(2)	444	(2)	(2)	1,469
Des Moines	1,667	20,016	2,692	6	1,659	1,559	3,113	75	44	1,064	3,262	(3)	39,344	5,100	1,598
Springfield, Mass	(2)	(2)	(2)	(2)	(2)	(2)	1,614	114	(2)	1,791	5,044	135	(2)	(2)	464
Wichita	(2)	(2)	(2)	(2)	(2)	(2)	1,939	(3)	17	248	1,192	(3)	25,492	4,129	1,642
Sioux City	1,447	13,063	667	6	2,040	2,040	953	(3)	666	25	952	(3)	20,221	1,946	430

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[1] The areas are identified by the principal city in each and are listed in descending order according to the 1940 population of the areas.
[2] Area did not report this type of service.
[3] No organized service in this field.
[4] Data for 1942 not available.
[5] Excludes births.
[6] Includes Boy Scouts, Girl Scouts, and Camp Fire Girls.
[7] Data for area not available; exchange operates on State-wide basis. The average monthly number of clearings in State in 1943 was 5,483.

TABLE 11.—*Percent change from 1942 to 1943 in average monthly figures for selected types of health and welfare service as reported by each of 43 urban areas*

Area [1]	Child welfare							Family welfare and relief									
	Children under protective and foster care					Day-care services (children served)	Women under care in maternity homes	Private agencies (cases)	Cases receiving public assistance				Service and relief to transients and travelers (cases)	Institutional care			Legal aid (cases opened)
	Total	In parents' homes	In relatives' homes	In foster-family homes	In institutions				Public general relief	Special types of assistance				Shelter		Days' care to aged, etc.	
										Aid to dependent children	Old-age assistance	Aid to the blind		Meals	Lodgings		
All areas reporting, total	−6	−10	−7	−5	−4	(2)	−7	+58	−47	−22	−3	−3	(2)	−40	−31	−5	−18
Public auspices	−4	−4	(3)	−3	−6	(2)	(4)	-------	−47	−22	−3	−3	(2)	−65	−62	−9	−51
Private auspices	−8	−12	−12	−7	−4	(2)	−7	+58	-------	-------	-------	-------	(2)	−29	−22	(3)	−13
Chicago	−6	(5)	−9	−6	−8	(2)	−13	+88	−45	+7	−3	−5	(2)	−56	−32	−4	(6)
Los Angeles	−1	+5	−1	−3	−5	(6)	+7	+60	−46	−40	(3)	−7	(2)	−35	−41	(6)	(6)
Detroit	(6)	(6)	(6)	(6)	(6)	(2)	−13	+100	−52	−32	−10	−8	(2)	(6)	(6)	−13	−17
Pittsburgh	−3	−2	−11	−6	+1	(2)	−6	+46	−48	−30	−3	(3)	(2)	−29	−13	(6)	−2
Cleveland	−8	+2	−5	−16	(5)	(2)	−16	+81	−59	−19	−4	−12	(2)	−42	−38	(6)	−18
St. Louis	−8	−26	+19	−6	−6	(2)	−18	+77	−42	−8	−4	+10	(6)	−52	−47	(6)	−18
Baltimore	−8	−17	+19	−8	−8	(2)	(4)	+33	−27	−35	−13	−16	(2)	−16	+4	−1	−9
Buffalo	−3	+1	+6	−9	−1	(2)	−14	−13	−57	−52	−12	−17	(2)	−48	−29	−3	+1
Boston	(6)	(6)	(6)	(6)	(6)	(6)	−6	+27	−39	−32	−5	−4	(2)	−26	−33	(6)	−16
Milwaukee	−3	−21	−6	−3	+4	(2)	+2	+50	−62	−36	−7	−5	(2)	−27	−12	−4	−20
Washington, D. C	(6)	(6)	(6)	(6)	(6)	(6)	(6)	+39	−40	−26	−11	−4	(6)	(6)	(6)	(6)	(5)
San Francisco	−2	+7	+10	−14	+7	(2)	+6	+101	−55	−51	−6	−9	(2)	−83	−81	+1	+35
Cincinnati	−26	−37	−46	+7	−3	(2)	−16	+22	−47	+2	−1	−5	(2)	−54	−46	(3)	−16
Houston	−4	(5)	−21	−6	−1	(2)	(4)	+50	−33	−37	+10	+35	(2)	−71	−54	−6	(7)
Minneapolis	−16	−23	−13	(5)	+12	(2)	+53	−56	−58	−33	−3	13	(6)	(6)	(6)	+8	−33
New Orleans	−3	−4	−13	+14	−6	(6)	(4)	+138	−17	−4	+18	+9	(2)	−15	−6	−3	+31
Atlanta	−6	+6	−25	−7	−4	(2)	(4)	+146	−44	+7	+14	+12	(2)	−59	−63	−2	0
Kansas City, Mo	−3	−8	−1	+8	−5	(2)	(4)	+130	−55	−21	−12	0	(2)	−15	−14	+3	−61
Indianapolis	(6)	(6)	(6)	(6)	(6)	(2)	(4)	+101	−52	−34	−10	−3	(2)	−31	−46	(6)	−9
Birmingham	(3)	−8	(4)	+14	−17	(6)	(4)	+104	−12	−14	+13	+7	(2)	−44	−50	−7	(7)
Newark	(6)	(6)	(6)	(6)	(6)	(2)	(4)	(6)	−47	−33	(6)	(6)	(2)	−16	−19	(6)	(6)
Dallas	−5	−3	(4)	+6	−10	(2)	(4)	+117	−40	−22	+11	+31	(7)	−39	−39	+9	(6)
Columbus	(5)	−13	(4)	+4	+3	(2)	−4	+124	−31	−14	−2	−13	(2)	(6)	(6)	−4	(4)
Louisville	+3	+20	+10	+1	−7	(2)	(4)	+109	−31	+2	−12	(4)	(2)	−18	−6	(6)	−38
Akron	+7	+6	+16	+10	+1	(2)	(4)	(6)	−39	−27	−7	−11	(7)	−29	−7	−56	(6)
Denver	−20	−43	0	+2	+1	(2)	−11	(6)	−34	−27	−2	−10	(2)	(8)	(5)	(6)	−13
St. Paul	−4	−4	+14	−7	−1	(2)	−14	+45	−51	−41	−6	0	(2)	(6)	(6)	−2	(4)
Dayton	−4	−8	−1	+1	−7	(2)	(4)	+57	−55	−26	−7	−10	(7)	−65	−71	−6	(6)
Syracuse	+1	+28	+38	−9	−9	(6)	(4)	+144	−48	−28	(5)	+6	(2)	−75	−54	−9	(6)
Richmond	+2	0	+11	+15	−18	(6)	(4)	+57	−17	−21	−9	+10	(2)	−26	−27	−3	(4)
Providence	−5	−3	+3	−7	−15	(2)	(4)	+127	+40	+3	−2	(4)	(2)	−17	−19	(6)	−8
Hartford	(6)	(6)	(6)	(6)	(6)	(6)	(6)	+37	(6)	+27	−12	+19	(2)	(8)	(8)	(6)	−29
Omaha	(6)	(6)	(6)	(6)	(6)	(2)	(4)	(6)	−51	−38	−9	−10	(2)	−82	−80	(6)	(7)
Grand Rapids	(8)	(8)	(8)	(8)	(8)	(7)	(4)	+80	−47	−26	−4	−9	(7)	(7)	(7)	(6)	−1
Oklahoma City	−8	−8	(4)	−13	−9	(2)	(4)	+54	−50	−30	(5)	−5	(2)	−34	−16	−8	(7)
Canton	−5	−11	−11	−1	−4	(7)	(7)	(6)	−37	−21	−3	−12	(2)	(7)	(7)	−5	(7)
Fort Worth	(5)	(7)	(7)	(4)	−2	(2)	(4)	+54	−56	−54	+4	+27	(2)	−44	−51	−9	(7)
New Haven	+6	+35	(4)	−4	+7	(2)	(7)	+15	−38	+15	−13	−22	(2)	−60	−58	(6)	−50
Wilkes-Barre	(6)	(6)	(6)	(6)	(6)	(7)	(6)	(6)	−49	−40	−4	−3	(2)	−9	−13	(6)	(7)
Des Moines	−10	−12	−14	−11	−2	(2)	(4)	+76	−58	−36	−6	−9	(2)	−99	−99	−16	(4)
Springfield, Mass	(6)	(6)	(6)	(6)	(6)	(2)	(7)	+48	−26	−43	−12	(6)	(2)	(6)	(6)	(6)	+2
Wichita	+16	(4)	(4)	−10	+2	(2)	(4)	+101	−44	−18	+1	+5	(7)	(7)	(7)	(7)	(7)
Sioux City	−11	−34	−29	+19	−5	(2)	(4)	+82	−61	−46	−6	−7	(2)	(7)	(7)	−8	(7)

See footnotes at end of table.

TABLE 11.—*Percent change from 1942 to 1943 in average monthly figures for selected types of health and welfare service as reported by each of 43 urban areas*—Continued

Area [1]	Health												Group work		
	Hospital in-patient service						Medical service—				Public-health nursing (field and office visits)	Medical-social service (patients)	Attendance at group activities	Number of local groups on national-program registers [10]	Social-service exchange (clearings)
	General and special			Tuberculosis and chronic			Clinic, other than mental hygiene (visits)	Mental-hygiene clinic (cases)	Patient's home and doctor's office (visits)	School-health programs (examinations)					
	Admissions [9]	Patient-days		Admissions	Patient-days										
		Total	Free		Total	Free									
All areas reporting, total	(3)	(5)	−10	−11	−6	−9	−17	−9	−32	−1	−6	−14	−6	+10	−10
Public auspices	−7	−3	−6	−13	−7	−9	−16	−13	−33	−1	−5	−10			+32
Private auspices	+2	+1	−19	(3)	−1	−11	−19	−8	−27	+29	−8	−16	−6	+10	−12
Chicago	−4	−2	−15	−22	−5	−6	−17	(6)	(6)	(6)	(6)	(6)	(6)	(6)	+5
Los Angeles	(6)	(6)	(6)	(6)	(6)	(6)	−8	+61	(6)	−21	−12	−12	(6)	+13	−10
Detroit	−2	−5	−14	+10	−5	−11	−20	(6)	−48	−25	+2	−29	−1	+15	(6)
Pittsburgh	+2	(5)	−7	−22	−10	−13	−18	+9	−38	(6)	(6)	+12	(6)	+6	−29
Cleveland	−3	−3	−5	(4)	−2	−2	−26	(6)	−36	−6	−19	−12	−11	+12	−20
St. Louis	+2	+1	−7	+4	−16	−19	−15	−14	−38	−12	−15	−15	+22	+8	−10
Baltimore	+3	−3	−10	−3	−2	−5	(6)	−1	−20	(6)	(6)	−79	+7	+12	−20
Buffalo	+6	+3	−23	(4)	−9	−10	−31	−22	(5)	+5	−9	−9	(6)	+1	−4
Boston	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	−27	(6)	(6)	−12	(6)	+6	(6)
Milwaukee	+3	+3	−5	−15	−7	−4	−28	+9	−35	−12	+8	+286	+3	+8	+8
Washington, D. C	+1	−2	−4	(4)	−6	−12	(6)	+9	−30	+13	−2	−15	−6	+8	−9
San Francisco	(5)	+5	−1	(4)	−4	−9	−14	(6)	−26	−6	−15	−6	−13	+2	−28
Cincinnati	+2	+1	−11	−3	+1	−10	−38	−38	−19	−16	−3	(6)	−14	+11	−8
Houston	(6)	(6)	(6)	(6)	(6)	(6)	−20	−18	−53	−17	−14	−100	−2	+34	−21
Minneapolis	(6)	(6)	(6)	(6)	(6)	(6)	−29	(6)	−56	−1	−10	(6)	−14	+7	−7
New Orleans	+6	+6	−2	−57	−33	−33	−16	−24	−9	−100	−8	(5)	+8	(6)	−18
Atlanta	+4	+1	−9	(4)	−8	−8	+2	(7)	−16	−5	+8	−38	(6)	+10	+8
Kansas City, Mo	−1	+4	−5	(4)	−11	−13	−34	+27	−20	+1	−4	(6)	−22	(6)	−43
Indianapolis	(6)	(6)	(6)	(6)	(6)	(6)	−11	(6)	−9	+5	+1	(7)	−7	+9	−14
Birmingham	−37	−26	−10	(4)	−7	−5	+7	(7)	(7)	+316	−9	−27	−13	+3	−15
Newark	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	+2	+1	(6)	−19	−1	+14
Dallas	+11	+3	−10	(4)	−13	−13	−6	−26	−28	−22	−13	(6)	(5)	+18	−24
Columbus	+7	+6	−18	(4)	+15	+5	−34	(6)	−55	−6	−7	(6)	−12	−8	−7
Louisville	(6)	(6)	(6)	(6)	(6)	(6)	−9	+10	−17	(7)	−11	−19	−9	+22	−2
Akron	+1	(5)	−28	(4)	−19	−19	−1	+4	−55	−16	−11	(7)	−24	(6)	−26
Denver	(6)	(6)	(6)	(6)	(6)	(6)	−27	−40	−15	+25	−7	−20	(5)	+36	+17
St. Paul	+3	(5)	−12	(4)	−1	−8	−30	−9	−44	−2	−3	(6)	−1	+7	+32
Dayton	+8	+10	−52	(4)	−2	−2	(6)	+1	(6)	+8	−6	(7)	(6)	(6)	−17
Syracuse	−1	(3)	−23	(4)	−7	−6	−18	−53	+66	−8	−6	+14	−19	(3)	+10
Richmond	+9	+6	+8	(4)	+4	+4	−12	+1	(6)	−17	−3	+1	−10	+14	−26
Providence	+1	+2	−9	(4)	−11	−15	−24	(4)	(6)	−6	−6	(6)	+13	+10	(11)
Hartford	(6)	(6)	(6)	(6)	(6)	(6)	(6)	−75	(6)	(6)	(6)	−13	−2	+4	−29
Omaha	(6)	(6)	(6)	(6)	(6)	(6)	−12	(7)	(6)	(7)	−24	(7)	+32	+8	−23
Grand Rapids	+3	−1	−20	(4)	−3	−4	−12	−100	(6)	(6)	(6)	−1	(6)	+18	(3)
Oklahoma City	−2	−1	−12	(4)	+10	+10	−24	−2	−75	−12	−11	(7)	−7	+11	−26
Canton	+9	+6	+16	(4)	−26	−21	+2	(7)	(6)	−78	−9	(7)	(6)	(6)	−41
Fort Worth	−7	+10	(3)	(4)	−3	−3	−18	(7)	−2	(4)	+2	(7)	−20	+19	−20
New Haven	+3	+6	−15	(7)	(7)	(7)	−7	−22	−24	+62	−6	+41	−3	−8	+56
Wilkes-Barre	−6	+1	−1	(4)	−7	−7	−22	(5)	(6)	(6)	(6)	−5	(6)	(6)	−44
Des Moines	−1	+11	−25	(4)	+2	+13	−35	+36	−61	+7	+1	(7)	−21	+11	−1
Springfield, Mass	(6)	(6)	(6)	(6)	(6)	(6)	−34	+4	(6)	−1	−8	−1	(6)	(6)	−26
Wichita	(6)	(6)	(6)	(6)	(6)	(6)	−57	(7)	−86	−67	−33	(7)	−2	+30	+15
Sioux City	+13	+10	+21	(4)	−6	−6	−42	(7)	−22	(4)	−11	(7)	−17	+11	−9

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[1] The areas are identified by the principal city in each and are listed in descending order according to the 1940 population of the areas.
[2] Change not computed; 1942 and 1943 figures not comparable owing to revision of reporting procedures in 1943.
[3] Increase less than 0.5 percent.
[4] Change not computed; 1942 figure less than 50.
[5] Decrease less than 0.5 percent.
[6] Area did not report this type of service.
[7] No organized service in this field.
[8] Data for 1942 not available.
[9] Excludes births.
[10] Includes Boy Scouts, Girl Scouts, and Camp Fire Girls.
[11] Data for area not available; exchange operates on State-wide basis.

APPENDIX—VOLUME OF SERVICES, 1944

Average monthly figures showing the volume of selected types of health and welfare services in 39 urban areas in 1944 are shown in the appendix table. Although the coverage of the 1944 data is similar to that for 1943 in terms of the services included, not all the figures for the 2 years are comparable, because of changes in the number and identity of the individual agencies for which data are included.

A general review of the data available for areas reporting in both years indicates that in most fields the changes in the volume of services provided during 1944 as compared with 1943 were in the same direction as those noted in the 1942–43 analysis. The exceptions to this were in the programs of maternity-home care, medical-social service, group activities of local agencies, and social-service exchanges—for which increases were reported in 1944 as compared with decreases in 1943. The downward trend of recent years in the volume of public general relief, aid to dependent children, shelter care, and medical service in the patient's home or in the doctor's office continued through 1944 although it appeared to be leveling off. Sizable increases

APPENDIX TABLE.—*Average monthly figures for selected types of health and welfare services as reported by each of 39 urban areas, 1944*

Area [1]	Child welfare							Family welfare and relief									
	Children under protective and foster care					Day-care services (children served)	Women under care in maternity homes	Private agencies (cases)	Cases receiving public assistance				Service and relief to transients and travelers (cases)	Institutional care			Legal aid (cases opened)
										Special types of assistance				Shelter		Days' care to aged, etc.	
	Total	In parents' homes	In relatives' homes	In foster-family homes	In institutions				Public general relief	Aid to dependent children	Old-age assistance	Aid to the blind		Meals	Lodgings		
All areas reporting, total	73,864	22,648	3,769	26,173	21,274	22,893	1,890	175,786	67,942	42,858	370,079	12,753	11,170	311,853	153,058	801,520	6,539
Public auspices	23,565	5,431	1,687	14,098	2,349	12,736	7	--------	67,942	42,858	370,079	12,753	203	43,552	14,183	414,062	592
Private auspices	50,299	17,217	2,082	12,075	18,925	10,157	1,883	175,786	--------	--------	--------	--------	10,967	268,301	138,875	387,458	5,947
Chicago	10,565	1,672	225	4,539	4,129	2,329	123	25,576	16,016	9,214	46,693	1,888	1,849	23,100	23,683	184,600	(2)
Los Angeles	5,495	1,497	118	2,267	1,613	(2)	105	21,425	4,799	2,054	69,705	2,803	1,235	48,600	14,439	(2)	(2)
Detroit	(2)	(2)	(2)	(2)	(2)	2,667	152	8,252	4,754	3,826	13,893	253	810	(2)	(2)	92,130	1,321
Pittsburgh	6,579	3,127	366	1,557	1,529	392	93	6,691	5,414	4,131	12,539	1,244	366	49,566	23,049	(2)	339
Cleveland	4,823	1,401	303	2,089	1,030	1,638	91	7,565	2,521	1,298	9,413	276	550	19,142	6,543	(2)	344
St. Louis	3,366	365	149	1,620	1,232	1,143	71	8,231	2,595	2,364	13,902	675	(2)	22,258	7,696	(2)	60
Baltimore	2,230	359	112	1,001	758	1,120	18	5,442	3,006	1,187	5,109	268	262	4,699	8,202	48,253	484
Buffalo	4,493	1,353	383	1,477	1,280	590	93	4,525	1,616	380	3,871	108	147	15,959	12,945	48,010	349
Boston	(2)	(2)	(2)	(2)	(2)	(2)	132	9,450	4,207	2,143	14,328	306	1,619	(2)	(2)	37,897	712
Milwaukee	2,248	305	123	792	1,028	116	56	5,539	1,409	801	7,994	310	174	11,990	8,817	41,344	188
San Francisco	2,827	697	97	1,134	899	1,409	115	8,168	1,074	299	10,921	404	438	23	124	67,451	284
Cincinnati	4,196	2,129	287	979	801	1,171	73	4,340	1,635	674	9,605	258	493	14,094	5,190	66,288	372
Houston	(2)	(2)	(2)	(2)	(2)	553	21	3,574	630	361	9,030	292	213	1,065	352	4,739	(3)
Minneapolis	3,477	2,079	211	1,022	165	595	140	5,446	232	669	11,305	223	(2)	(2)	(2)	30,891	101
New Orleans	1,595	592	120	255	628	(2)	36	2,703	1,546	2,863	6,197	364	278	3,977	2,739	28,753	71
Atlanta	863	96	55	425	287	1,781	23	4,297	689	620	8,263	296	401	494	266	11,785	245
Kansas City, Mo	1,882	821	65	544	452	1,132	41	2,350	983	617	9,220	354	440	35,539	8,711	28,081	277
Indianapolis	(2)	(2)	(2)	(2)	(2)	740	25	2,793	457	713	6,203	289	139	7,767	4,584	(2)	117
Newark	(2)	(2)	(2)	(2)	(2)	409	25	2,988	1,298	1,073	(2)	(2)	161	14,510	5,920	(2)	(2)
Dallas	685	100	4	184	397	289	25	2,833	328	498	11,084	354	(3)	917	307	1,452	(2)
Columbus	1,281	312	28	458	483	343	51	2,965	1,035	336	7,741	232	74	(2)	(2)	8,675	17
Louisville	1,906	491	151	594	670	280	24	3,309	559	398	3,534	138	226	3,631	4,924	(2)	364
Akron	1,260	552	106	410	192	102	19	(2)	662	186	3,287	77	(3)	7,183	3,365	7,005	(3)
Denver	1,577	256	74	519	728	285	55	(2)	2,141	1,056	11,420	148	245	4,848	870	(2)	188
St. Paul	2,540	1,190	169	1,046	135	414	65	3,162	1,000	284	4,443	122	66	(2)	(2)	25,335	30
Dayton	1,017	214	73	416	314	362	7	1,682	476	220	4,977	101	(3)	80	53	8,372	(2)
Syracuse	1,702	491	114	566	531	(2)	9	2,149	1,034	245	3,133	58	47	3,185	2,052	25,487	(2)
Richmond	952	193	68	508	183	379	35	2,115	755	388	12,946	100	221	2,911	1,215	17,930	21
Providence	2,231	1,396	155	344	336	555	11	4,000	1,251	528	3,019	39	141	5,056	2,220	(2)	71
Hartford	(2)	(2)	(2)	(2)	(2)	(2)	(2)	1,862	(2)	372	1,985	37	175	4,076	2,399	(2)	131
Omaha	(2)	(2)	(2)	(2)	(2)	(2)	29	1,628	412	589	3,557	86	89	695	420	(2)	(3)
Grand Rapids	223	36	7	74	106	(2)	27	1,858	500	536	5,871	92	(2)	(2)	(3)	(2)	89
Oklahoma City	369	31	28	74	236	623	33	1,787	223	604	5,604	131	15	316	211	3,155	(3)
Canton	1,124	339	85	534	166	(3)	(3)	(2)	339	161	3,701	73	32	(3)	(3)	7,620	(3)
Fort Worth	420	0	0	35	385	75	19	2,359	163	161	6,980	163	67	448	125	3,286	(3)
New Haven	1,255	418	22	533	282	457	(3)	1,563	460	328	2,203	42	76	5,724	1,637	(2)	107
Springfield, Mass	(2)	(2)	(2)	(2)	(2)	34	(3)	1,215	627	157	2,263	(2)	110	(2)	(2)	(2)	257
Wichita	432	111	51	130	140	607	19	1,335	722	407	2,092	89	(3)	(3)	(3)	(3)	(3)
Sioux City	251	25	20	47	159	303	29	609	374	117	2,048	60	11	(3)	(3)	2,981	(3)

See footnote at end of table.

were reported for 1944 over 1943 in the volume of day-care services, maternity-home care, private family-agency service, service to transients and travelers, membership in national-program groups, and social-service-exchange clearings. The general pattern of decreases in health and welfare services, which is noted in the analysis of the 1942–43 ,data, is not so marked for 1943–44.

APPENDIX TABLE.—*Average monthly figures for selected types of health and welfare service as reported by each of 39 urban areas, 1944*—Continued

Area [1]	Health												Group work		Social-service exchange (clearings)
	Hospital in-patient service						Medical service in—				Public-health nursing (field and office visits)	Medical-social service (patients)	Attendance at group activities of local agencies	Members of local groups on national-program registers [5]	
	General and special			Tuberculosis and chronic			Clinic, other than mental hygiene (visits)	Mental-hygiene clinic (cases)	Patient's home and doctor's office (visits)	School health programs (examinations)					
	Admissions [4]	Patient-days Total	Patient-days Free	Admissions	Patient-days Total	Patient-days Free									
All areas reporting, total	162, 370	2, 186, 434	660, 208	1, 077	317, 570	262, 754	761, 602	3, 499	25, 480	59, 096	324, 769	24, 465	2, 186, 804	396, 196	193, 942
Public auspices	28, 019	578, 037	482, 962	787	257, 800	235, 561	449, 801	686	23, 242	28, 536	203, 593	5, 236			
Private auspices	134, 351	1, 608, 397	177, 246	290	59, 770	27, 193	311, 801	2. 813	2, 238	30, 560	121, 176	19, 229	2, 186, 804	396, 196	193, 942
Chicago	27, 780	351, 091	107, 850	163	45, 919	41, 895	148, 732	(2)	(2)	(2)	(2)	(2)	(2)	(2)	14, 360
Los Angeles	(2)	(2)	(2)	(2)	(2)	(2)	88, 225	270	(2)	695	23, 113	(2)	(2)	47, 929	11, 542
Detroit	15, 744	195, 390	64, 352	131	27, 036	23, 269	63, 114	(2)	2, 654	641	43, 595	1, 231	133, 880	36, 088	(2)
Pittsburgh	11, 181	179, 156	42, 879	40	14, 042	12, 198	30, 747	306	4, 773	(2)	(2)	1, 909	(2)	21, 125	18, 063
Cleveland	9, 137	127, 126	40, 212	31	11, 375	10, 827	28, 394	(2)	1, 913	6, 071	18, 965	4, 760	157, 316	19, 833	13, 138
St. Louis	10, 904	160, 645	57, 588	47	21, 058	17, 563	50, 550	246	363	4, 526	12, 092	3, 317	180, 278	(2)	9, 398
Baltimore	8, 710	141, 995	48, 429	122	49, 975	40, 225	(2)	484	1, 120	(2)	(2)	1, 213	53, 959	20, 069	6, 233
Buffalo	6, 289	96, 045	20, 018	24	11, 337	9, 914	13, 249	285	1, 400	5, 593	14, 596	1, 118	(2)	20, 962	5, 650
Boston	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	1, 791	(2)	(2)	4. 098	(2)	14, 456	(2)
Milwaukee	7, 048	82, 222	20, 628	49	18, 507	13, 448	15, 835	139	542	6, 702	29, 806	646	44. 556	13, 798	8, 577
San Francisco	7, 435	106, 694	32, 232	15	9, 610	5, 740	39, 374	(2)	(2)	(2)	11, 103	1, 585	138, 857	11, 344	6, 591
Cincinnati	6, 062	81, 300	19. 404	187	31, 667	20, 535	22, 565	148	1, 552	5, 106	13, 254	(2)	120, 734	14, 879	8, 709
Houston	(2)	(2)	(2)	(2)	(2)	(2)	18, 819	119	121	2, 319	5, 058	(3)	73, 416	14, 615	5, 528
Minneapolis	(2)	(2)	(2)	(2)	(2)	(2)	7, 930	(3)	89	(2)	(2)	(2)	91, 351	13, 488	8, 219
New Orleans	8, 436	94, 253	53, 969	51	8, 291	8, 291	42, 124	87	34	(3)	7, 956	1, 020	37, 173	(2)	3, 406
Atlanta	4, 437	47, 819	16, 612	13	5. 622	5, 622	33. 842	(3)	1, 399	1, 534	8, 839	637	111, 842	8, 787	2, 576
Kansas City, Mo	4, 487	63, 260	22, 060	12	5, 166	5, 011	9, 967	66	240	1, 554	7, 460	(2)	77, 259	(2)	5, 338
Indianapolis	(2)	(2)	(2)	(2)	(2)	(2)	8, 865	(2)	942	1, 591	8, 404	(3)	93, 291	11, 681	2, 540
Newark	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	5, 870	10, 026	(2)	37, 309	6, 570	5, 403
Dallas	4, 165	44, 529	13, 661	19	2, 716	2, 716	25, 151	136	228	1, 094	10, 645	108	98, 359	10, 444	3, 547
Columbus	3, 557	45, 637	5, 577	34	8, 836	7, 464	7, 775	(2)	(3)	(2)	6, 412	(2)	109, 286	6, 404	3, 310
Louisville	(2)	(2)	(2)	(2)	(2)	(2)	24, 946	193	184	(3)	9, 977	247	39. 139	6, 435	6, 866
Akron	2, 646	28, 269	2, 416	16	3. 472	(2)	6, 729	70	141	1, 331	11, 712	(3)	43, 801	10, 185	2, 051
Denver	(2)	(2)	(2)	(2)	(2)	(2)	8, 616	121	908	1, 731	6, 356	729	89, 944	9, 479	2, 955
St. Paul	3, 812	54, 865	18, 640	2	2, 255	1, 783	6, 687	111	644	242	6, 216	(2)	36, 572	10, 221	16, 293
Dayton	2, 386	29, 772	4, 866	13	3, 046	3, 046	(2)	69	(2)	1, 789	7, 175	(2)	(2)	(2)	1, 891
Syracuse	2, 458	31, 097	3, 805	18	6, 622	6, 406	5, 558	49	1, 834	2, 914	6, 532	560	45, 978	7, 587	2, 994
Richmond	1, 600	28, 954	19, 150	15	5, 731	5, 212	9, 815	125	(2)	1, 296	7, 162	332	52, 207	5, 549	3, 233
Providence	2, 824	63, 826	21, 169	34	13, 465	10, 559	10, 216	46	(2)	1, 467	9, 684	(2)	71, 219	3, 936	(6)
Hartford	(2)	(2)	(2)	(2)	(2)	(2)	(2)	102	(2)	(2)	(2)	269	38, 042	8, 269	1, 887
Omaha	(2)	(2)	(2)	(2)	(2)	(2)	7, 576	(3)	(2)	(3)	3, 521	(3)	51, 133	7, 627	2, 886
Grand Rapids	1, 767	23, 074	4, 470	10	3, 098	2, 916	2, 642	(3)	(2)	(2)	(2)	197	(2)	6, 459	1, 369
Oklahoma City	1, 435	22, 970	9, 919	5	1, 837	1, 837	2, 317	(2)	349	1, 103	1, 566	(3)	39, 261	11, 225	594
Canton	1, 816	19, 287	1, 339	17	3, 197	2. 587	1, 137	(3)	(3)	247	4, 117	(3)	(2)	(2)	1, 024
Fort Worth	2, 239	21, 423	5, 060	4	1, 758	1, 758	9, 375	(3)	1, 791	614	2, 260	(3)	27, 721	5, 367	2, 821
New Haven	2, 292	29, 467	3, 182	(3)	(3)	(3)	8, 564	183	203	677	9, 546	356	35, 427	4, 230	2, 311
Springfield, Mass	(2)	(2)	(2)	(2)	(2)	(2)	(2)	144	(2)	1, 737	5, 404	133	(2)	(2)	514
Wichita	(2)	(2)	(2)	(2)	(2)	(2)	1, 360	(3)	31	632	1, 232	(3)	34, 717	4. 836	1, 302
Sioux City	1, 723	16, 268	721	5	1, 932	1, 932	806	(3)	234	20	985	(3)	22, 777	2, 319	823

[1] The areas are identified by the principal city in each and are listed in descending order according to the 1940 population of the areas.
[2] Area did not report this type of service.
[3] No organized service in this field.
[4] Excludes births.
[5] Includes Boy Scouts, Girl Scouts, and Camp Fire Girls.
[6] Data for area not available, exchange operates on a State-wide basis. (The average monthly number of clearings in 1944 was 4,047.)

THE 43 URBAN AREAS PARTICIPATING IN THE SOCIAL-STATISTICS PROJECT, 1943

Principal city in area	1940 population of area	Reporting area [1] includes—
Chicago	4, 063, 342	Cook County.
Los Angeles	2, 785, 643	Los Angeles County.
Detroit	2, 015, 623	Wayne County.
Pittsburgh	1, 411, 539	Allegheny County.
Cleveland	1, 217, 250	Cuyahoga County.
St. Louis	1, 090, 278	City, and St. Louis County.
Baltimore	859, 100	City.
Buffalo	798, 377	Erie County.
Boston	770, 816	City.
Milwaukee	766, 885	Milwaukee County.
Washington, D. C	663, 091	City.
San Francisco	634, 536	City (coterminous with San Francisco County).
Cincinnati	621, 987	Hamilton County.
Houston	528, 961	Harris County.
Minneapolis	498, 225	City, and village of Edina; but for the special types of public assistance the territory comprises Hennepin County with a population of 568,899.
New Orleans	494, 537	City (coterminous with Orleans Parish).
Atlanta	479, 828	DeKalb and Fulton counties.
Kansas City, Mo	477, 828	Jackson County.
Indianapolis	460, 926	Marion County.
Birmingham	459, 930	Jefferson County.
Newark	429, 760	City.
Dallas	398, 564	Dallas County.
Columbus	388, 712	Franklin County.
Louisville	385, 392	Jefferson County.
Akron	339, 405	Summit County.
Denver	322, 412	City (coterminous with Denver County).
St. Paul	309, 935	Ramsey County.
Dayton	295, 480	Montgomery County.
Syracuse	295, 108	Onondaga County.
Richmond	266, 185	City, and Chesterfield and Henrico counties.
Providence	253, 504	City.
Hartford	248, 128	City, and towns of Bloomfield, East Hartford, Newington, West Hartford, Wethersfield, and Windsor.
Omaha	247, 562	Douglas County.
Grand Rapids	246, 338	Kent County.
Oklahoma City	244, 159	Oklahoma County.
Canton	234, 887	Stark County.
Fort Worth	225, 521	Tarrant County.
New Haven	223, 093	City, and towns of East Haven, Hamden, and West Haven.
Wilkes-Barre	221, 687	City, and townships of Dallas, Hanover, Kingston, Plains, and Wilkes-Barre, and boroughs of Ashley, Courtdale, Dallas, Edwardsville, Forty Fort, Kingston, Larksville, Luzerne, Plymouth, Pringle, Sugar Notch, Swoyerville, and Warrior Run.
Des Moines	195, 835	Polk County.
Springfield, Mass	175, 882	City, and towns of East Longmeadow, Longmeadow, and West Springfield.
Wichita	143, 311	Sedgwick County.
Sioux City	103, 627	Woodbury County.

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[1] The territory included in each reporting area was determined locally; it usually coincides with the area served by the local council of social agencies or the community chest.

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